UNIVERSAL CURRICULUM
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

Participant Manual

UTC 6

Case Management for Addiction Professionals

4th Edition, 2020

COLOMBO PLAN

DAP
Drug Advisory Programme

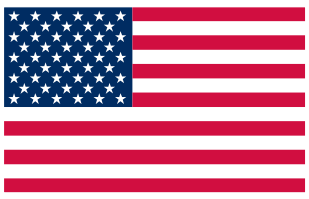
Colombo Plan Drug Advisory Programme (DAP)
The Universal Treatment Curriculum for Substance Use Disorders (UTC)

Basic Level UTC Series

Case Management for Addiction Professionals

Participant Manual

3rd Edition - 2017



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Disclaimer

The substance use disorder treatment interventions described or referred to herein do not necessarily reflect the official position of INL or the U.S. Department of State. The guidelines in this document should not be considered substitutes for individualized client care.

4th Edition

Published 2020 - Sri Lanka

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PARTICIPANT ORIENTATION

Introduction

Welcome! This training will provide you with an overview of models and practices of case management.

Course 6: *Case Management for Addiction Professionals* is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan Drug Advisory Programme. More information on the Colombo Plan can be found at http://www.colombo-plan.org.

The overall goal of the training series is to reduce the significant health, social, and economic problems associated with substance use disorders (SUDs) by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce. The training prepares counselors for professional certification at the entry level by providing the latest information about SUDs and their treatment and facilitating hands-on activities to develop skills, confidence, and competence.

Congratulations for taking the time to learn more about your work!

The Training

The five modules in this training series may be delivered over 2 consecutive days or may be offered over the course of several weeks or months. Your trainers have provided you with a specific agenda.

The learning approach for this training includes:

- Trainer-led presentations and discussions;
- Frequent use of creative learner-directed activities, such as small-group and partner-to-partner exercises and presentations;
- Reflective writing exercises;
- Periodic reviews to enhance learning retention; and
- Learning assessment exercises.

Your active participation is essential to making this a positive and productive learning experience!

Goals and Objectives for Course 6

Training goals

- To provide an overview of basic principles, functions, and models of case management; and
- To provide an opportunity for participants to apply information about case management to their own practices.

Learning objectives

Participants who complete Course 6 will be able to:

- Describe the concept and importance of case management;
- Define "case management";
- Understand how case management helps coordinate services and reduce fragmentation;
- Understand how case management is currently being performed in their program; and
- Apply the principles of case management to their own practice.

Training materials

Training materials include:

- This *Participant Manual*;
- A notebook; and

Each module of your *Participant Manual* includes:

- Training goals and learning objectives for the module;
- A timeline;
- PowerPoint slides printed three to a page with space for you to write notes;
- Resource Pages containing additional information or exercise instructions and materials; and
- A module summary.

The *Participant Manual* also has a glossary (Appendix A) and a list of resources (Appendix B).

Your trainers will give you a notebook to use as your personal journal. You can use this journal in a number of ways. You can note:

- Topics you would like to read more about;
- A principle you would like to think more about;

- A technique you would like to try;
- Ways you might be able to add some of the things you're learning to your practice; and
- Possible barriers to using new knowledge.

Your trainers will also ask you to complete short writing assignments.

TAP 21 was developed in the United States to provide a common foundation on which to base training and certification of addiction professionals. The publication addresses these questions:

- What professional standards should guide counselors working with people with SUDs?
- What is an appropriate scope of practice for the field of SUD counseling?
- Which competencies are associated with positive treatment outcomes?
- What knowledge, skills, and attitudes should all SUD treatment professionals have in common?

TAP 21 can serve as a useful reference for you. Keep in mind, however, that it takes time and experience to develop counseling competence. TAP 21 represents an ideal set of goals, not a starting point. Don't get overwhelmed! You'll get there.

Getting the Most From Your Training Experience

To get the most from your training experience:

- If you have a supervisor, speak to him or her before the training begins. Find out what his or her expectations are for you.
- Think about what you want to learn from each module.
- Come to each session prepared; review the manual pages for the modules to be presented.
- Be an active participant. Participate in the exercises, ask questions, write in your journal, and think about what additional information you want.
- Speak to your supervisor (or co-workers, if you have no supervisor) after the training. Talk about what you learned to be sure you understand how the information relates to your job.
- Discuss with your supervisor or co-workers ways that you can put your learning into practice, and continue to follow up on your progress.
- Have fun!

U.S. DEPARTMENT OF STATE
MODULE 0

MODULE - 0
U.S. DEPARTMENT of STATE

Congratulations!

> As a participant in this training, you are part of a rapidly growing global community of substance use professionals

U.S. DEPARTMENT of STATE 0.2 MODULE - 0

How is this global community of substance use professionals expanding?

In the last decade, a growing number of people are:

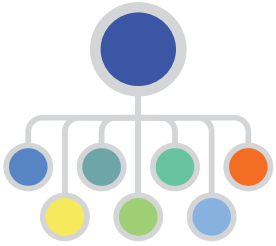
- ✓ being trained
- ✓ being credentialed
- ✓ studying at universities with specialized addiction programs
- ✓ operating in the context of a larger drug control system
- ✓ adhering to science and research-based approaches
- ✓ joining professional substance use associations
- ✓ networking through professional associations

U.S. DEPARTMENT of STATE 0.3 MODULE - 0

Who are the members of this global community of substance use professionals?

Individuals working worldwide in the substance use prevention and treatment fields in government, non-governmental organizations, civil society, and the private sector

Organizations that act as portals or "doorways" for individuals to join the global community



U.S. DEPARTMENT of STATE 0.4 MODULE - 0

ISSUP INTERNATIONAL SOCIETY OF SUBSTANCE USE PROFESSIONALS

ISSUP stands for the International Society of Substance Use Professionals

- ✓ ISSUP was launched by INL in 2015 as a global, not for profit, non-governmental organization to professionalize the global prevention and treatment workforce.
- ✓ ISSUP provides members with opportunities to share knowledge, exchange experiences, and stay abreast with current research in the field

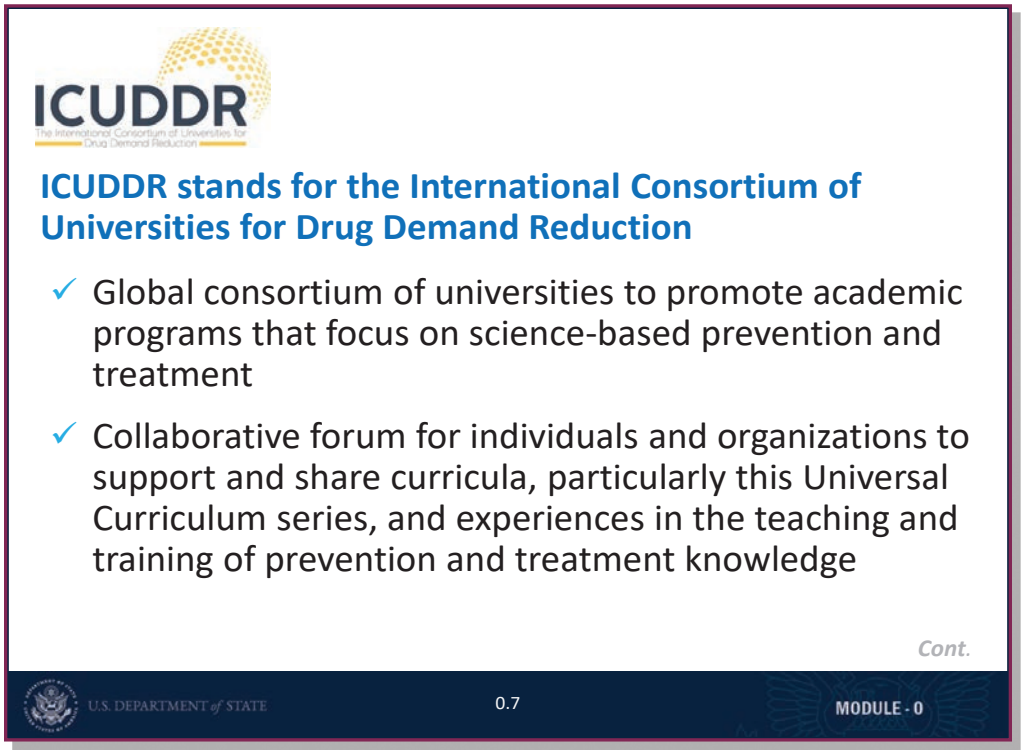
Cont.

U.S. DEPARTMENT of STATE 0.5 MODULE - 0

ISSUP stands for the International Society of Substance Use Professionals

- ✓ There are more than 10,000 ISSUP members worldwide
- ✓ Join one of ISSUPs four levels of membership for free at: www.issup.net
- ✓ You can earn credit for this and other courses with ISSUP

U.S. DEPARTMENT of STATE 0.6 MODULE - 0


ICUDDR
The International Consortium of Universities for Drug Demand Reduction
ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction
✓ Global consortium of universities to promote academic programs that focus on science-based prevention and treatment
✓ Collaborative forum for individuals and organizations to support and share curricula, particularly this Universal Curriculum series, and experiences in the teaching and training of prevention and treatment knowledge
Cont.
U.S. DEPARTMENT of STATE
0.7
MODULE - 0

ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction

Learn about specialized addiction programs at universities worldwide at www.icuddr.com

THE COLOMBO PLAN

Global Centre for Credentialing and Certification

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

- ✓ The hours that you put into this training can be logged at GCCC and qualify you for exams and professional credentials
- ✓ GCCC credentials will help accelerate your career by indicating your passion and commitment to high standards

Cont.

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

Learn about how to apply the latest in research-based prevention and treatment at: www.globalccc.org

U.S. DEPARTMENT of STATE 0.10 MODULE - 0

Who funds and supports this global community of substance use professionals?

The U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) which is funded by the U.S. taxpayer

Where does this global community of substance use professionals meet?

- ✓ Digitally- through ISSUP and its networks and
- ✓ Face to face – through trainings, on university campus settings, and at conferences held at the global, national regional and local levels

How does this global community of substance use professionals operate?

In the context of a larger international drug control environment that includes:

- United Nation's three international Drug Control Treaties or "Conventions"
- Commission on Narcotic Drugs (CND)
- International Narcotics Control Board (INCB)

What are the key international organizations which operate in the context of this larger drug control environment?

DAP	The Colombo Plan Drug Advisory Program (DAP)
Inter-American Drug Abuse Control Commission	The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS)
AFRICAN UNION	The African Union Commission (AUC)
UNODC	The United Nations Office on Drugs and Crime (UNODC)
World Health Organization	The World Health Organization (WHO)

ISSUP INTERNATIONAL SOCIETY OF SUBSTANCE USE PROFESSIONALS

How can I participate in this global community of substance use professionals?

The easiest way is to become an active member of ISSUP!

- ✓ Register for free on the ISSUP website at www.issup.net
- ✓ Click on the "Apply for Membership" icon
- ✓ Select one of four levels of membership -all are free!
- ✓ Begin networking with others on an ongoing basis

It takes only a few minutes to register and you can immediately connect with over 10,000 ISSUP members worldwide!

What are the benefits of being an active member of this global community of substance use professionals?
You can:

- ✓ Stay informed
- ✓ Implement best practices
- ✓ Access training and mentoring
- ✓ Turn training into credentials
- ✓ Access job postings
- ✓ Access up-to-date research
- ✓ Join a professional network
- ✓ Interact with other professional networks

0.16

MODULE - 0

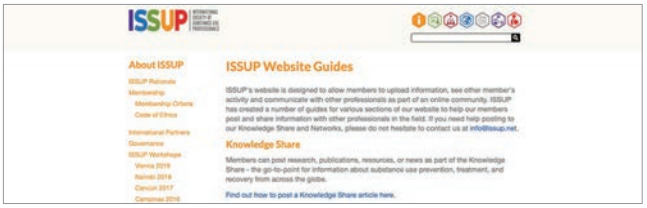
CALL TO ACTION

Next Steps

1. Join ISSUP at www.issup.net
2. Complete this training to earn credit
3. Send your credit hours to GCCC at www.globalccc.org

Participate in ISSUP

- Post on ISSUP: Find easy instructions for how to post on the ISSUP website
- Engage ISSUP's Networks: Connect with colleagues and broaden your impact



U.S. DEPARTMENT of STATE 0.17 MODULE - 0

MODULE 1

TRAINING INTRODUCTION

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Summary 45

Content and Timeline	
Activity	***Time***
Ceremonial welcome	20 minutes
Trainer welcome, housekeeping, and ground rules	10 minutes
Partner exercise: Introductions	50 minutes
Presentation: Training materials	10 minutes
Presentation: Why this training?	20 minutes
Break	*15 minutes*
Large-group exercise: Training expectations	15 minutes
Large-group exercise: Fragmented services	25 minutes
Large-group exercise: Coordinated services	10 minutes
Reflective exercise	10 minutes

Module 1 Goals and Objectives

Training goals

- To create a positive learning community and environment;
- To give participants background information about why the training is being done;
- To give participants a summary of the overall training goals, objectives, and learning approach of the course; and
- To introduce participants to the concept and importance of case management in providing services to clients requiring services beyond those provided by substance use disorder counselors.

Learning objectives

Participants who complete Module 1 will be able to:

- Explain the overall training goals and learning objectives of the 2-day training;
- State at least one personal learning expectation; and
- Describe the concept and importance of case management.

Module 1 Learning Objectives

- Explain the overall UTC training goals and at least 4 objectives of the 2-day training
- State at least 1 personal learning goal
- Describe the concept and importance of case management

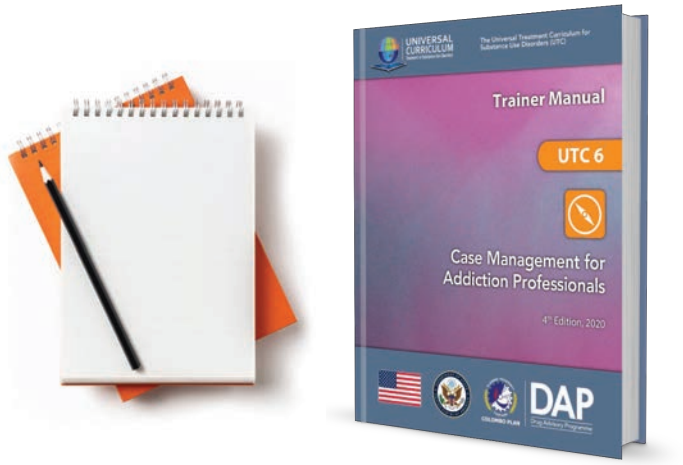
1.2

Partner Exercise: Introductions

- What is your name?
- In what town do you live and work?
- What is your job title?
- What does your job entail?
- How did you become interested in the counseling profession?

1.3

Training Materials



1.4

The Global Problem

- 269 million people between the ages of 15 and 64 used illicit substances at least once in 2018

Source: UNODC (2020). World Drug Report 2020. New York: United Nations

1.5

The Global Problem

- 35.6 million people between the ages of 15 and 64 suffer from drug use disorders
- People who suffer from drug use disorder need treatment

Source: UNODC (2020). World Drug Report 2020. New York: United Nations.

1.6

Diagnostic and Statistical Manual- 5 (DSM-5)

- Published by the American Psychiatric Association
- Provides standards criteria for the classification of mental disorders
- Substance Use Disorder (SUD) is defined as a problematic pattern of substance use leading to clinically significant impairment in daily life or distress
- Level of severity is measured on a continuum from mild to severe

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author

1.7

International Classification of Diseases (ICD-11)

- Published by WHO and covers health as a whole
- Covers more types of substances than ICD-10
- Disorders due to the use of substances are characterized by the pattern of use and consequences. ICD-11 identifies them as follows:
  - Single episode of harmful use of substances
  - Harmful pattern of use of substances
  - Substance dependence
  - Intoxication
  - Withdrawal

ICD-11 : International Classification of Disease for Mortality and Morbidity Statistics. (Eleventh Revision ed.): World Health Organisation.

1.8

The Global Problem

- An estimated 11.3 million people injected drugs in 2018
- About 12.6 percent (1.4 million) of those who inject drugs are HIV positive
- About 48.5 percent (5.5 million) of those who inject drugs are infected with Hepatitis C

Source: UNODC. (2016). World drug report 2016. New York: United Nations.

1.9

The Global Problem

- Global consequences of SUDs are far-reaching and include:
  - Higher rates of hepatitis and tuberculosis
  - Lost productivity
  - Injuries and deaths from automobile and other accidents
  - Overdose deaths
  - Suicides
  - Violence

1.10

The Global Problem

- "There continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries."

Yuri Fedotov, Executive Director, UNODC (2010-2019)

Source: UNODC. (2011). *World drug report 2011* (p. 9). New York: United Nations.

1.11

Training Series Goals

- Build International capacity through
  - Training;
  - Professionalizing; and
  - Expanding the workforce.

1.12

Courses in the Series

- UTC 1: *Introduction to the Science of Addiction* (3 days)
  - Foundational, not how-to or skills-based course
  - Overview of the physiology of addiction as a brain disease and the pharmacology of psychoactive substances

1.13

Courses in the Series

- UTC 2: *Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals* (5 days)
  - Builds the foundation for understanding SUD treatment and the continuum of care
  - Provides an overview of recovery and recovery management, stages of change, components of SUD treatment and evidence-based practices

1.14

Courses in the Series

- UTC 3: *Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals* (3 days)
  - Provides an overview of co-occurring disorders (COD), its relationship to one another
  - Discusses COD treatment and related issues as well as mental and medical disorders that commonly co-occur with SUD

1.15

Courses in the Series

- UTC 4: *Basic Counseling Skills for Addiction Professionals* (5 days)
  - Provides the basic understanding of the helping relationship
  - Provides opportunities to enhance core counseling and motivational interviewing skills
  - Introduces psychoeducation and recovery skills building as components of SUD treatment

1.16

Courses in the Series

- UTC 5: *Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals* (5 days)
  - Provides an overview of effective, integrated screening, assessment and treatment planning in SUD treatment;
  - Introduces the use of valid screening and assessment tools
  - Highlights the importance of documentation in the process

1.17

Courses in the Series

- UTC 7: *Crisis Intervention for Addiction Professionals* (2 days)
  - Develops an understanding of crisis
  - Provides guidelines for crisis management, managing suicide risk, and avoiding your own crisis (counselor self-care)

1.18

Courses in the Series

- UTC 8: *Ethics for Addiction Professionals* (4 days)
  - Develops an understanding of ethics in SUD treatment practice
  - Provides an overview of the standards of professional conduct as defined in the Code of Ethics
  - Introduces the ethical decision-making model and provides opportunities for practice

1.19

Course 6 Learning Objectives

- Describe concept and importance of case management
- Define “case management”
- Understand coordination of services
- Understand case management as practiced in your program
- Apply principles of case management

1.20

Break

15 minutes

1.21

Large-Group Exercise: Training Expectations

- Write down two expectations
- Select partner from group
- Trade cards
- Determine how expectation will support training

1.22

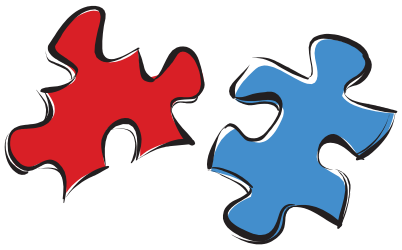
Large-Group Exercise: Fragmented Services

- Gather
- Catch balls
- Spread out
- Seek services

1.23

Large-Group Exercise: Fragmented Services

- Where do you go?
- Whom do you see?
- How do you start?
- What happens then?



1.24

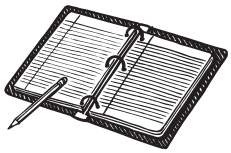
Large group exercise: Coordinated Services

- In addition to SUD treatment, clients need variety of services
- Ten volunteers come forward and name a service

1.25

Reflective Exercise

- Some topics for entries will be assigned
- Other entries completed throughout the day or after training
- For now, write your thoughts about fragmented and coordinated services:
  - How do these concepts relate to your practice?



1.26

Resource Page 1.1: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Criteria for Substance Use Disorder[1]

Substance Use Disorder (SUD) is a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for that substance (as specified in the DSM-5 for each substance).
    b. The use of a substance (or a closely related substance) to relieve or avoid withdrawal symptoms.

[1] https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics

Resource Page 1.2 : ICD-11 Classification of Mental and Behaviour Disorder

Disorders due to substance use include single episodes of harmful substance use, substance use disorders (harmful substance use and substance dependence), and substance-induced disorders such as substance intoxication, substance withdrawal and substance-induced mental disorders, sexual dysfunctions and sleep-wake disorders.

Disorders due to use of substances

Disorders due to use of substance are characterised by the pattern and consequences of substance use. In addition to Substance intoxication, Substance has dependence-inducing properties, resulting in Substance dependence in some people and Substance withdrawal when use is reduced or discontinued. Substance is implicated in a wide range of harms affecting most organs and systems of the body, which may be classified as Single episode of harmful use and Harmful pattern of use. Harm to others resulting from behaviour during Substance intoxication is included in the definitions of Harmful use of substance. Several substance-induced mental disorders and substance-related forms of neurocognitive impairment are recognised.

Single episode of harmful use of substances

A single episode of use of substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following:

(1) behaviour related to intoxication;

(2) direct or secondary toxic effects on body organs and systems; or

(3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behavior due to substance intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies.

This diagnosis should not be made if the harm is attributed to a known pattern of substance use.

Exclusion

- Harmful pattern of use of substance
- Substance Dependence

Harmful pattern of use of substances

A pattern of psychoactive substance use that has caused damage to a person's physical

[1] www.who.int/substance_abuse/terminology/ICD10ClinicalDiagnosis.pdf

or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of psychoactive substance use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following:

(1) behaviour related to intoxication;

(2) direct or secondary toxic effects on body organs and systems; or

(3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to psychoactive substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of psychoactive substance applies.

Exclusion

- Substance Dependence
- Episode of Harmful Use of Substance

Substance Dependence

Dependence on a psychoactive substance is a disorder of regulation of psychoactive substance use arising from repeated or continuous use of psychoactive substance. The characteristic feature is:

- a strong internal drive to use the psychoactive substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the psychoactive substance.
- physiological features of dependence may also be present, including tolerance to the effects of the psychoactive substance, withdrawal symptoms following cessation or reduction in use of the psychoactive substance, or repeated use of psychoactive substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.

The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if psychoactive substance use is continuous (daily or almost daily) for at least 1 month.

Exclusion

- Episode of Harmful Use of Substance
- Harmful pattern of use of substance

Intoxication

Intoxication is a clinically significant transient condition that develops during or shortly

after the consumption of a psychoactive substance that is characterized by disturbances in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of psychoactive substance and their intensity is closely related to the amount consumed. Presenting features may include impaired attention, inappropriate or aggressive behaviour, lability of mood, impaired judgment, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur.

Withdrawal

Withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psycyhoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, transient visual, tactile or auditory hallucinations, and distractibility. Less commonly, the withdrawal state is complicated by seizures. The withdrawal state may progress to a very severe form of delirium characterized by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations.

Note: The detailed diagnostic criteria can be accessed at WHO site.

Note: At the time of the updating of this Course, the ICD-11 was in the final stages of revision and not yet formally released. However, INL and the Treatment Expert Advisory Group, in the interest of providing UC trainees with the latest and most current guidance on substance use disorders, requested inclusion of the ICD-11 language, "as is."

Resource Page 1.3: The Universal Treatment Curriculum for Substance Use Disorders (UTC) Basic Level Training Series

UTC 1:	*Introduction to the Science of Addiction*
UTC 2:	*Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals*
UTC 3:	*Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals*
UTC 4:	*Basic Counseling Skills for Addiction Professionals*
UTC 5:	*Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals*
UTC 6:	*Case Management for Addiction Professionals* **(this course)**
UTC 7:	*Crisis Intervention for Addiction Professionals*
UTC 8:	*Ethics for Addiction Professionals*

Module 1—Training Introduction, Summary

The Global Problem

- Psychoactive substance use continues to be a global problem. A survey done by the United Nations Office on Drugs and Crime (or UNODC) found that, in 2018, 269 million people between ages 15 and 64 used illicit substances at least once in 2018.[1]
- Illicit substances in the survey included opioids, cannabis, cocaine, other amphetamine-type stimulants, hallucinogens, and ecstasy, among others.
- These figures and other global statistics have a broad range. This is due to the difficulty of compiling such numbers. Different countries track and record statistical information in different ways, and global organizations such as UNODC and the World Health Organization (WHO) need to allow for these differences in their estimates.
- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are a subset of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
- There are two classification systems used in the diagnosis of drug use disorders or
- SUDs, the Diagnostic Statistical Manual (DSM) and the International Classification of Diseases (ICD).
- Diagnostic Statistical Manual (DSM), published by the American Psychiatric Association, offers a common language and standards criteria for the classification of mental disorders.
- In 2013, the APA updated the DSM, replacing the categories of substance abuse and substance dependence with a single category: substance use disorder (SUD). SUD is defined as a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the 11 criteria occurring in a 12-month period. The level of severity is measured on a continuum from mild to severe.
- The symptoms associated with SUD fall into four major groupings: impaired control; social impairment; risky use; and, pharmacological criteria (i.e. tolerance and withdrawal).
- Another classification system is the International Classification of Diseases (ICD), published by the World Health Organization.
- It is distinguished from the DSM in that it covers health as a whole. Under ICD-11, patterns of psychoactive substance use are labelled,
    - Single episode of harmful use of a psychoactive substance - refers to a single episode of use of psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.

1. UNODC. (2020). World drug report 2020 New York: United Nations.

- Harmful use - if the pattern is causing damage to health. The damage may be physical (as in the case of hepatitis from self-administration of injected drugs) or mental (i.g. episodes of depressive disorder secondary to heavy consumption of alcohol), and
- Dependence - if the use of a substance or a class of substances takes on a much more higher priority for a given individual than other behaviors that once had greater value. There is compulsion to use drugs and physical signs of a withdrawal state upon abstinence.
- Intoxication – a clinically significant transient condition that develops during or shortly after the consumption characterised by disturbances in consciousness, cognition, perception , affect behaviour or coordination.
- Withdrawal – is a clinically significant cluster of symptoms, behaviors and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psychoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psycho-motor agitation, transient visual, tactile or auditory hallucinations, and distractibility.

- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are those subset of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
- The U.N Survey also found that:[1]
  - 11.3 million people injected drugs in 2018
  - About 12.6 percent (1.4 million) of those who inject drugs are HIV positive.
  - About 48.5 percent (5.5 million) of those who inject drugs are infected with Hepatitis C.
- Global consequences of SUDs are far-reaching and include, for example:
  - Higher rates of HIV/AIDS, hepatitis and tuberculosis;
  - Lost productivity;
  - Injuries and death due to automobile and other accidents;
  - Overdose hospitalizations and deaths;
  - Suicides; and
  - Violence.
- The numbers are significant. Yuri Fedotov, Executive Director of UNODC (2010 to 2019), notes that "there continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries."[2] There are a number of reasons for this, but one reason is a lack of adequate treatment capacity.

1. UNODC. (2020). World drug report 2020 New York: United Nations.
2. UNODC. (2011). World drug report 2011 (p.9). New York: United Nations.

The training series

- This course is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan.
- The overall goal of the training series is to reduce the health, social, and economic problems associated with SUDs by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce.
- The series prepares counselors for professional certification at the entry level by providing them with necessary information and with specific skills training. See You will find a list of the courses included in the training series on Resource Page 1.3 in your manuals.

Other courses in the series

- Course 1: Introduction to the Science of Addiction is a 3-day course that presents a comprehensive overview of addiction, provides an understanding of the physiology of addiction as a brain disease, and describes the pharmacology of psychoactive substances.
- Course 2: Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals is a 5-day foundational course. By this we mean that it provides a necessary foundation for learning about SUD treatment. It is not a how- to or skillsbased course, but it provides a context for the skills-based courses later in the series. Course 2 provides an overview of recovery, recovery management, stages of change, principles of effective treatment, components of treatment, factors affecting treatment outcomes, and evidence-based practices, including couples and family counseling.
- Course 3: Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals is a 3-day course. It is also a foundational course and provides an overview of the relationship of co-occurring disorders to one another and to SUD related treatment issues. It outlines brief descriptions of the most commonly cooccurring mental and medical disorders with SUD.
- Course 4: Basic Counseling Skills for Addiction Professionals is a 5-day skills-based course. It provides an overview of the helping relationship. It also provides opportunities to learn and practice core counseling and basic motivational interviewing skills which are essential at every stage of treatment and in every type of counseling situation, including working with families. Basic group (for clients and family members) counseling and psychoeducational group skills also are covered in the course.
- Course 5: Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals is a 5-day skills-based course that teaches effective, integrated assessment and treatment/service planning. It also addresses the importance of documentation in the treatment process.
- Course 6: Case Management for Addiction Professionals is a 2-day foundational and skills-based course that provides an overview of case management in SUD treatment

and provides skills practice in case management functions such as planning, linkage, monitoring, advocacy, consultation, and collaboration.

- Course 7: Crisis Intervention for Addiction Professionals, a 2-day course, addresses the concept of crisis as a part of life and provides guidelines for and practice in crisis management, including managing suicide risk. It also addresses ways counselors can avoid personal crisis situations by providing information and exercises about counselor self-care.
- UTC 8: Ethics for Addiction Professionals is a 4-day course that aims to develop an understanding of ethics in SUD treatment and provides an overview of professional conduct as defined in the Code of Ethics. It provides the opportunity to learn and practice the process of ethical decision making. The course also addresses the importance of supervision as part of ethical practice.

Why case management?

- Often—maybe even most of the time—programs try to refer clients to services without using case management or similar support services. Let me give you an example
- The usual result—services are fragmented. By "fragmented services" we mean those that are split apart and unconnected to one another.
- At worst, when services are fragmented, the clients just give up and don't get the additional services at all.
- It's hard, isn't it? But that's what often happens to clients who need services beyond treatment for their SUDs—and most do.
- Let's look at some of the problems that arise when services are fragmented:
    - First, as the exercise showed, the clients may not know where to go. The SUD treatment counselor can say, "Go to this facility at this address," but sometimes a facility is a large complex that provides multiple services, and it can be hard to know where to go within it.
    - Once the client arrives at the facility, he or she may not know whom to see:
        - The counselor who referred the client might have been able to give a name, or maybe not.
        - Or perhaps this isn't the right person to see.
        - Or maybe the identified person isn't with that program anymore.
        - It can be frustrating for the client to be passed from one person to another before finding the right one to talk to—if he or she finds the right one at all.
- Then, how does the client start? Let's say he or she has been referred to a mental health facility—the SUD treatment counselor believes there may be an underlying mental health disorder that needs specialized treatment. So the client arrives.

- Can he or she explain why the counselor believed mental health services are necessary?
- Will the client have to go through his or her history again, perhaps duplicating lengthy discussions with the substance abuse counselor?

- It's always hard to start with a new service provider, and fragmented services can make the client do so two or more times.
- We can understand the client who gets frustrated and gives up on treatment altogether!
- Let's say none of these situations has occurred or they've all been resolved. Fragmentation can still cause problems. Let's talk again about the client referred to a mental health specialist.
  - Should he or she continue seeing the SUD counselor? What if the two counselors' goals are different?
  - What if one counselor recommends one type of follow-up treatment, the other a different one?
- Again, the client is left confused and, possibly, is getting substandard, fragmented services.
- In addition, presence of structural barriers such as lack of transportation, lack of insurance coverage, child care issues, language barriers can present problems for clients to access the service they need.

MODULE 2

OVERVIEW OF CASE MANAGEMENT

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PowerPoint slides 54
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Summary..... 85

Content and Timeline	
Activity	***Time***
Introduction to Module 2	5 minutes
Partner exercise: Definitions of case management	40 minutes
Lunch	*60 minutes*
Interactive presentation: Why case management?	40 minutes
Reflective and partner exercise: Importance of effective case management	15 minutes
Interactive presentation: Principles of effective case management	40 minutes
Break	*15 minutes*
Presentation and Reflective exercise: Functions of case management	65 minutes
Small-group exercise: Functions of case management (case study)	40 minutes
Review exercise preparation and day 1 wrap-up	10 minutes

Module 2 Goals and Objectives

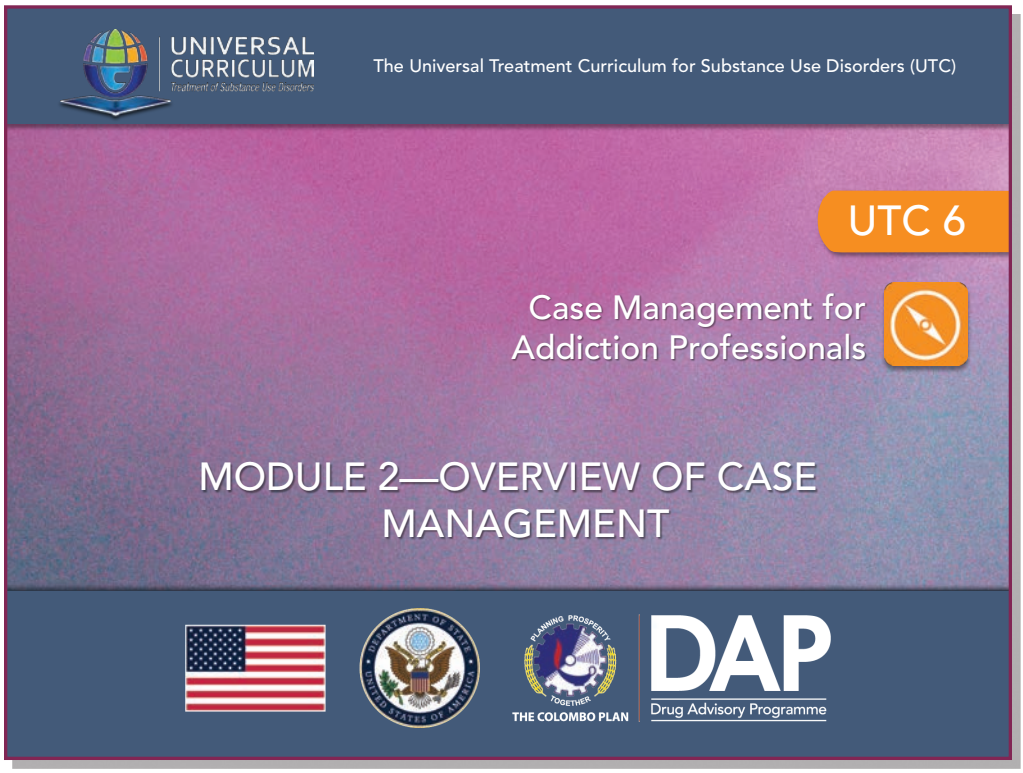
Training goals

- To develop a definition of case management;
- To identify reasons for using case management; and
- To provide an overview of the principles and functions of case management.

Learning objectives

Participants who complete Module 2 will be able to:

- Provide a definition of case management;
- Give at least three reasons for using case management;
- List eight principles of case management; and
- Describe five functions of case management.



Module 2 Learning Objectives

- Provide your own definition of case management
- Give at least 3 reasons for using case management
- List 8 principles of case management
- Describe 5 functions of case management

2.2

Partner Exercise: Definitions of Case Management

- Write a definition
- Find a partner
- Trade ideas
- Develop a joint definition

2.3

Case Management

- Assessing the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs

Source: Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1998. (Treatment Improvement Protocol (TIP) Series, No. 27.)
Available from: https://www.ncbi.nlm.nih.gov/books/NBK64863/

2.4

Case Management vs. Direct Counseling Services

- Case Management is related to acquiring resources that are external to the client, such as obtaining housing, income, coordination and referral to treatment facilities.
- Direct Conseling focuses on internal issues such as relationships with others, relapse prevention planning, etc.

2.5

Intra-program vs. Inter-program

- Intra-program: Facilitating services within one's own organization
  - Example: Helping a client move from residential treatment to outpatient continuing care
- Inter-program: Facilitating services at other agencies in the community
  - Example: Referring a client for family therapy

2.6

Lunch

60 minutes

2.7

Why Case Management?

- Enhance client engagement and motivation
  - Case manager helps the client better focus on treatment.
  - Case management can help clients meet immediate, pressing needs that can interfere with treatment engagement.
  - Having these needs met early in the process can engage clients and increase their feelings of trust
  - Case management can motivate clients to remain in treatment because they feel supported.

2.8

Why Case Management?

- Ensure appropriate SUD treatment services

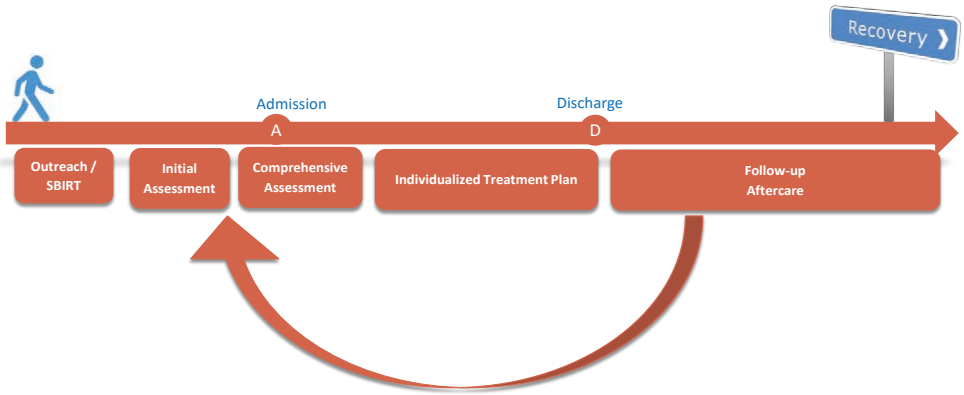
2.9

Why Case Management?

- Help clients build recovery capital to help them manage a range of practical issues and build a life in recovery

2.10

Care Pathway, care journey, treatment journey



Ref:
Models of Care for Treatment of Adult Drug Misusers (NTA, 2002) NTA Business Plan 2005/06 (NTA, 2005)
NTA Treatment Effectiveness Strategy Briefing 2005–08 (online at www.nta.nhs.uk) Treating Drug Misuse Problems: Evidence of Effectiveness (NTA, 2006)

Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document.
National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive

2.11

Recovery Capital and Case Management

- Case Management takes into consideration the recovery capital of the client – not just the client's needs/ problems
- 'Recovery capital' refers to 'breadth and depth of internal and external resources that can be drawn on to initiate and sustain recovery'.

Cloud, W., & Granfield, R. (2004). A life course perspective on exiting addiction: The relevance of RC in treatment. NAD Publication (Nordic Council for Alcohol and Drug Research), 44, 185–202.

2.12

Types of Recovery Capital

- Personal recovery capital: Personal strengths/ resources
  - Physical - health, money, housing
  - Human - skills, values, optimism
- Family/social recovery capital: Support from family and friends
- Community recovery capital – SUD treatment resources
- Case Managers help the client recognize, utilize and further strengthen these resources

2.13

Using Recovery Capital

- Assess and focus on client's strengths
- Appropriate referrals
- Client-directed treatment and recovery plans

2.14

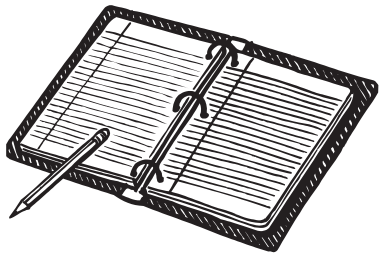
Using Recovery Capital

- Community outreach
- Assess and focus on client's strengths
- Appropriate referrals
- Professional- and client-directed treatment and recovery plans

2.15

Reflective and Partner Exercise

- Write down 2 important reasons for case management
- Find a partner
- Compare and discuss reasons



2.16

Principles of Case Management

- Single point of contact
- Client driven
- Advocacy
- Community based

2.17

Principles of Case Management (continued)

- Pragmatic (practical)
- Anticipatory
- Flexible
- Culturally sensitive

2.18

Single Point of Contact

- Promotes coordination
- Ensures continuity
- Provides client an anchor

2.19

Client Driven

- Responds to client's needs
- Identifies and clarifies options
- Helps client obtain services

2.20

Advocacy

- Promotes client's best interests
- Communicates with other systems
- Speaks out on behalf of clients

2.21

Community Based

- Helps client obtain local services
- Ensures smooth transition to the new program or next level of care
- Focuses on a specific client or the community at large

2.22

Pragmatic

- Sets priorities
- Resolves specific immediate issues
- Maintains long-term focus

2.23

Anticipatory

- Understands natural course of SUDs
- Foresees and addresses problems
- Works with treatment team

2.24

Flexible

- Adapts to individual's needs
- Identifies suitable community resources
- Reevaluates when necessary

2.25

Culturally Sensitive

- Pays attention to the client's cultural orientation
- Makes culturally appropriate referrals

2.26

Confidentiality

- In communication with other programs
- In communication with others in the client's life
  - Family
  - Friends
  - Employers
- Know and follow confidentiality laws and regulations

2.27

Break

15 minutes

2.28

Case Management Functions

- Assessment
- Planning
- Linkage
- Monitoring
- Advocacy

Source: Joint Commission, http://www.jointcommission.org

2.29

Assessment

- Is a foundation for treatment planning
- Establishes a baseline for measuring a client's progress
- Prioritizes a client's needs

Source: Center for Substance Abuse Treatment. Substance abuse treatment: Addressing the specific needs of women. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. (Treatment Improvement Protocol (TIP) Series, No. 51.) Chapter 4: Screening and Assessment. Available from: https://www.ncbi.nlm. nih.gov/books/NBK83253/ CSAT (https://www.ncbi.nlm.nih.gov/books/NBK83253/#_tip51_ch4_s2_

2.30

Elements of Assessment

- Current and past substance use and substance treatment
- Medical conditions or complications
- Emotional, behavioral, and cognitive status

2.31

Elements of Assessment (continued)

- Readiness to change
- Potential for relapse or continued use
- Recovery environment

2.32

Reflection

- Apply some or all of these elements to your assessment of the client
- Write down how this assessment relates to case management

2.33

Planning

- Identifies main problems and strengths
- Identifies client goals
- Determines intervention options

2.34

Reflection

- What were your client's main problems and strengths?
- What were your client's goals?
- What types of services could help this client achieve those goals?

2.35

Linkage and Referral

- Critical part of case management
- *Inter-program* case management connects agencies

2.36

Organizational Boundaries

- All organizations have boundaries
- Case managers move across boundaries to make connections
- Some agencies have rigid boundaries, whereas others are more flexible

2.37

Reflection

- What programs can provide the services you identified for your client?
- What do you know about each program and its boundaries?
  - How difficult is it to refer a client to the program?
  - What kinds of experiences have your clients had there?
  - Is it easy or difficult to communicate with the program staff ?

2.38

Monitoring

- Ensures that the client engages in services
- Follows the client's progress
- Identifies barriers to services
- Coordinates the services the client needs

2.39

Reflection

- What difficulties might arise when coordinating services for your client?
- What barriers to monitoring can or did your client or a particular program present?
- In what ways was monitoring helpful (or could have been helpful)?

2.40

Advocacy

- A function *and* a principle
- Speaks out on issues of concern
- Applies influence

2.41

Reflection

- In what ways did you need to advocate for your client?
- How might advocating have made a difference for your client?

2.42

Small-Group Exercise

- Form 4 small groups
- Read case study (Resource Page 2.1)
- Prepare a presentation demonstrating how each of the five functions might apply
  - Assessment
  - Planning
  - Linkage
  - Monitoring
  - Advocacy

2.43

Review and Evaluation

- Thoughts on Post-its
- Daily evaluation
- Have a good evening!

2.44

Resource Page 2.1: Case Study

Angella is a 25-year-old sex worker who has been in the sex trade since she was 16. Her mother was also a sex worker and died of AIDS a year ago at age 42.

Angella has two sisters and a brother. They don't approve of how she makes a living and have not been in touch with her for some time. She misses them and wishes she could reestablish a relationship with them.

Angella started using marijuana and drinking at age 12. Over the years, she has used a variety of drugs. She spent 6 months in a rehabilitation center when she was 20 but stayed in recovery only 9 months. When in treatment and recovery, Angella tried to change her life, but she could not find a job that lasted. She says she starts seeing old clients and using drugs again each time she loses a job. She began to inject heroin 4 years ago. She says she does that because sex work is too difficult unless she is high.

Angella occasionally goes to an SUD drop-in center. She told a professional there that she feels "tired and old" and wants to get out of sex work. She is scared she will "end up like my mother," but she has not been tested for HIV/AIDS. She does not fully trust the drop-in center staff or volunteers and feels hopeless.

Angella lost a job she had as a waitress a month ago and went back to walking the streets. She is currently homeless, staying with clients or other sex workers when she can. She says she often stays with whoever will give her heroin or a place to sleep.

Angella came in to the drop-in center last week and told the SUD counselor on staff that she hasn't been sleeping, has been eating poorly, and spends much of the day when she isn't with customers crying and thinking about getting high. She says she was beaten and raped last week. The worker noted that she still has large bruises on her face and arms.

Module 2—Overview of Case Management, Summary

Definition and conceptualization

- Case management is assessing the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs.[1]
- Case management is different in a critical way from the counseling services we're all familiar with. Case management focuses on acquiring resources that are external to the client, such as obtaining housing or income support; and direct counseling services focus on internal issues, including relationships with others, relapse prevention planning, and so on.
- Case management may be intra-program or inter-program:
    - Intra-program case management means facilitating services within one's own organization—for example, helping a client move from residential treatment to outpatient continuing care.
    - Inter-program case management means facilitating services for a client through other programs in the community—for example, referring a client to a job-training program.

Why case management?

- One of the purposes of case management is to enhance clients engagement and motivation to improve access to comprehensive continuum of services that promotes recovery and enables the substance abuse client to fully integrate into the society as a healthy, substance-free individual.[1] Fragmented services can discourage clients from obtaining or continuing services when, for example, they can't find the right person to talk to about what they need from a program.
    - By coordinating services, the case manager helps the client better focus on treatment.
    - Case management can help clients meet immediate, pressing needs that can interfere with treatment engagement.
    - Having these needs met early in the process can engage clients and increase their feelings of trust and belief that program staff members are listening and trying to help.
    - Case management can motivate clients to remain in treatment because they feel supported.

1. Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1998. (Treatment Improvement Protocol (TIP) Series, No. 27.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK64863/
2. TIP 27: Comprehensive Case Management for Substance Abuse Treatment. www.samhsa.gov

- Another purpose of case management is to ensure appropriate SUD treatment services are available. Clients most commonly have a range of treatment needs (medical, psychological, psychosocial) that most programs cannot adequately address under one roof. Programs often have a range of services and levels of service. For example, primary treatment is followed by continuing care.
- Case management serves to address the multiple needs experienced by clients when these needs cannot be addressed in a single program.
- Clients need help negotiating systems, even within one program.
- Intra-program case management ensures that clients can move from one level or type of treatment to another, without getting lost in the system.
- Case management can prepare clients to move to a different level of care (and often a different counselor), increasing clients' confidence and reducing their anxiety.
- Case management also helps clients build the resources they need to help them manage practical issues and build a life in recovery. These resources are called "recovery capital." These practical issues can include:
    - Housing assistance;
    - Job training or search assistance;
    - Transportation;
    - Child-care;
    - Language barrier;
    - Family therapy;
    - Treatment for mental disorders;
    - Medical care;
    - Engagement;
    - Active treatment phase; and
    - Continuing care.
- Case Management functions as a bridge for the substance use disorder client to receive comprehensive continuum of care from the first contact until he or she is able to integrate into the broader society.[1,2]

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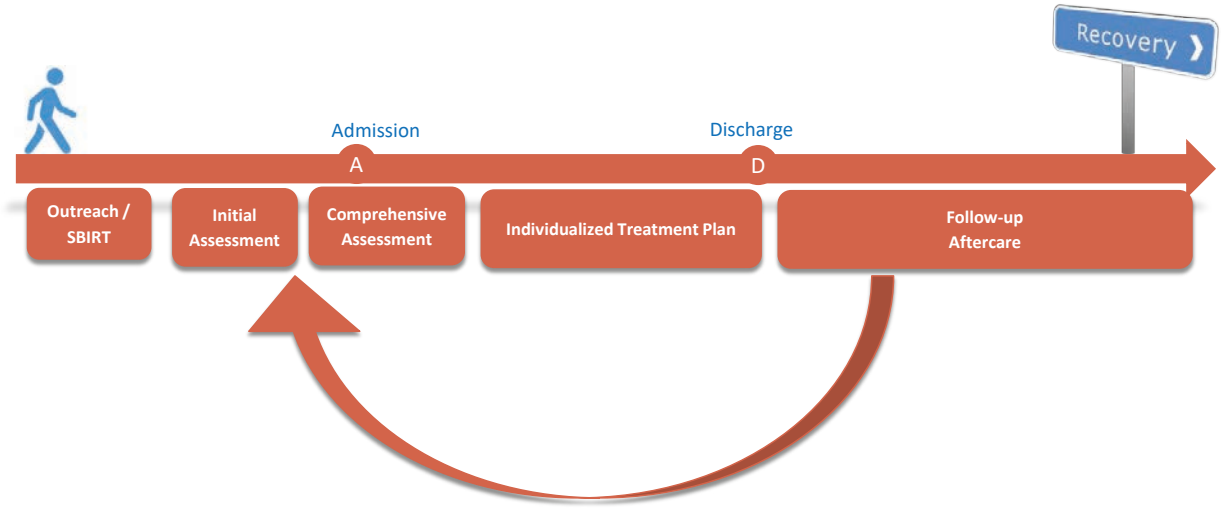
1. Ref: Models of Care for Treatment of Adult Drug Misusers (NTA, 2002) NTA Business Plan 2005/06 (NTA, 2005) NTA Treatment Effectiveness Strategy Briefing 2005–08 (online at www.nta.nhs.uk) Treating Drug Misuse Problems: Evidence of Effectiveness (NTA, 2006)
2. Doyle J, Ivanovic J (2010) National Drugs Rehabilitation Framework Document. National Drugs Rehabilitation Implementation Committee. Dublin: Health Services Executive



Recovery Capital and Case Management

- The case manager recognizes the needs of the clients and yet at the same time is well aware of the client's strengths, assets and resources which we refer to as 'recovery capital'.
- 'Recovery capital' is defined as the 'breadth and depth of internal and external resources that can be drawn on to initiate and sustain recovery'.[1]
- There are three types of recovery capital.

    1. Personal recovery capital refers to the strengths and resources that clients have and include physical and human recovery capital. Physical capital refers to those tangible resources the client has such as physical health, money, housing, access to transportation, food, clothing etc. Human capital refers to the client's education, vocational and interpersonal skills, values, optimism, knowledge, self-confidence, problem-solving capacities and other positive personal qualities that will support the client in recovery.

    2. Family members and friends who are willing to participate in treatment, social contacts who are in recovery, or individuals involved in recovery-related social activities can be considered as 'family/social recovery capital'

    3. Community recovery capital, which includes, local recovery role models, SUD treatment resources other than your own program, or mental disorder treatment resources, including emergency services. Sources of medical care, including specialty treatment for HIV/AIDS, Legal services, mutual support groups, like Narcotics Anonymous (NA), community support institutions, such as recovery centers or informal groups of recovering people, transitional and other housing programs; and sources of ongoing support and relapse prevention and early re-intervention, such as a counselor who will periodically call a recovering client to see how things are going.

1. Cloud, W., & Granfield, R. (2004). A life course perspective on exiting addiction: The relevance of RC in treatment. NAD Publication (Nordic Council for Alcohol and Drug Research), 44, 185–202.

- Case Managers help the client recognize and utilize these resources. The client is helped to build on these, increasing the support for recovery.
- Case Management is an integral part of the continuum of care extending from pre-treatment on to continuing care and the client's recovery capital is an important consideration in case management.
- Case Management services are provided based on the nature and intensity of client's problems as well as the client's resources. For example, knowing that the client is a high school drop-out with no formal training in any trade and needs a job placement presents only one part of the picture. Recognizing that client is knowledgeable about cars, can communicate very well and has a cheerful disposition changes the scenario.
- A major function of case management is determining which program or programs are most appropriate for a specific client, given his or her amount of recovery capital. Owning or having a vehicle to use or living in an area where excellent public transport facilities are available can make a great deal of difference if the client needs to access services or seek employment in a distant location.
- Assessing recovery capital on an on-going basis is an essential part of developing treatment or recovery plans. When plans are reviewed, efforts need to be made to identify additional resources or strengthen existing sources of recovery capital. The client can be encouraged to strengthen family ties with the extended family, make new friends and build the support network. Case Managers can also help strengthen support services in the community by providing guidance or assistance for example, serving on a program's board of directors or providing free consultation to a recovery support center.
- Treatment professionals—particularly case managers—can make the fullest use of clients' recovery capital by:
    - Engaging people with a small amount of recovery capital through aggressive community outreach programs. These people are having such a hard time that they are not going to reach out to us. Instead, we must find ways to reach out to them.
    - Assessing recovery capital on an ongoing basis, focusing on the client's strengths. This means applying the capital that the client does have while strengthening his or her capital in other areas.
    - Taking into consideration the client's recovery capital in making decisions regarding appropriate referrals. A major function of case management is determining which program or programs are most appropriate for a specific client, given his or her amount of recovery capital.
    - Using professional- and client-directed treatment and recovery plans. This means determining which resources need to be mobilized within the client, the family, and the community to support long-term recovery.
- In particular, we can support local movements aimed at increasing recovery support services and creating a community in which recovery can flourish by, for example,

serving on a program's board of directors or providing free consultation to a recovery support center.

Principles of Effective Case Management

- There are eight basic principles of effective case management: Case management services should:

1. Have a single point of contact;

   A single point of contact helps clients deal with other parts of health and social services systems. It promotes coordination. A coordinated approach ensures continuity. No matter the stage of treatment or changes in service providers, the case manager is involved from the beginning to the end of treatment. The single point of contact facilitates a therapeutic alliance with a strong inter-personal relationship. This relationship gives the client an anchor in what can be a lonely, confusing process. Sometimes two or more case managers work as a team, and together they are considered a single point of contact.

2. Be client driven

   Case management is client determined and responds to clients' needs. The case manager's role is to identify and clarify options; it is the client's role to choose from these options. It is not the case manager's job to convince the client that the services are needed. The case manager helps the client obtain the services the client has chosen.It is important for case managers to consider client's culture, values and goals when providing options.

3. Advocate for clients

   The case manager needs to promote the client's best interests. This may involve communicating with programs, legal systems, and legislative bodies. Advocacy can relate to a specific client—for example, ensuring that he or she receives needed service. It can also be broader in scope—for example, encouraging a program to adapt its admission policies to include a broader range of clients. Advocacy may even include such extreme measures as taking legal action to force another program to comply with a law regarding service provision. To be an advocate, a case manager must speak out on behalf of clients.

4. Be community based

   All case management approaches are community based because they help the client get services from local providers. For example, the case manager might work with a client who is about to move from an inpatient facility to a community-based outpatient program. This support requires working with both programs to ensure a smooth transition to the new program. This effort can be client specific, focusing on a particular client, or it can be broader, working with another program to facilitate future referrals and processes.

5. Pragmatic or practical

   Case management is pragmatic; it must take priorities into consideration. For example, the client who has nowhere to live might be more interested in finding housing than dealing with an SUD. We must address clients' problems in a way that resolves immediate, specific issues while not losing focus on the longer term issues they are facing.

6. Anticipatory

   Case manager must be able to understand the natural course of addiction and recovery, foresee potential problems, understand options, and take action. The case manager then works with the treatment team to plan ahead for the next course of action.

7. Flexible

   The case manager not only must adapt to the individual's needs but also must modify the approach based on the available community resources that are most suitable for a particular client. Flexibility also means reevaluating a placement that doesn't seem to be working well.

8. Culturally sensitive

   Case management must be culturally sensitive. The case manager needs to pay attention to the client's cultural orientation and make culturally appropriate referrals.

- Finally, the case manager must respect the client's confidentiality, as in all services. Case management by its nature involves communication with other programs. Almost always, it is necessary to get a client's consent (in writing) before discussing their cases with any other person or program. In some cities or countries, an oral consent may suffice in some situations.
- The case manager also may want to communicate with others in the client's life. In particular, the case manager may want to discuss the client's treatment and support needs with family members, friends, or employers.
- It is critical that a case manager knows and follows the laws and regulations governing his or her program and service community.

Case Management Functions

Throughout this training, we've been speaking of the case manager as an individual for whom case management is the primary responsibility. This isn't always the case. Sometimes it's a team of people within a program or even from two programs who serve as co-managers. In other cases, the SUD treatment counselor may also perform a case management role. The functions we're going to discuss apply to all case management activities, regardless of who is providing this service.

The functions of case management are:

1. Assessment

   Assessment is a process of defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.[1] It serves three purposes:

   - It is the foundation for treatment planning because the case manager assesses all the client's needs, not just one aspect of his or her condition.
   - Assessment establishes a baseline for measuring a client's progress because there is a record of the client's condition at the start of treatment.
   - It helps prioritize a client's needs; because the case manager has a broader understanding of the client needs across multiple domains.

   An assessment includes the client's:

   - Current and past substance use and substance use treatment, what worked in the past and his current goal;
   - Medical conditions or complications; and
   - Emotional, behavioral, and cognitive status.

   It also includes the client's:

   - Readiness to change;
   - Potential for relapse or continued use; and
   - Recovery environment and recovery capital.[1]

2. Planning

   Planning is based on the assessment and includes three basic elements:

   - Identifying the client's main problems and strengths. It's important to note that the client's main problem may not be the SUD. For example, a suicidal client may need an immediate mental health intervention before he or she can address the SUD.
   - Identifying the client's overall goals, not just the goals for the services you provide directly.
   - Determining intervention options available to help the client meet these goals. These interventions include not only the direct services your program provides, but also the steps you will take to obtain services and support from others.

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1. Center for Substance Abuse Treatment. Substance abuse treatment: Addressing the specific needs of women. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. (Treatment Improvement Protocol (TIP) Series, No. 51.) Chapter 4: Screening and Assessment.

   Available from: https://www.ncbi.nlm. nih.gov/books/NBK83253/ CSAT (https://www.ncbi.nlm.nih.gov/books/NBK83253/#_tip51_ch4_s2_

Case management evolves out of the assessment and the treatment plan, either as part of a client's overall treatment plan or as a separate case management plan.

3. Linkage/referral;

   Linkage is a critical part of case management because one program cannot meet all of a client's needs. The goal of inter-program case management is to connect programs to one another to provide more services to clients.

   All organizations have boundaries. Case managers move across these boundaries to make connections.

   Some programs have rigid boundaries, whereas others are more flexible. Some operate by themselves and establish no connections to other organizations; others establish a single contact or limited linkages with other programs and service providers. Ideally, programs form effective connections with more than one other organization.

4. Monitoring

   An important role of the case manager is monitoring what happens to clients as they go through the system. This role typically includes four activities:

   - Ensuring that the client engages in services—following up on referrals and keeping appointments;
   - Following the client's progress, usually through contacts with the other programs' service providers;
   - Identifying barriers to service, such as a program's long waiting list or its viewing the client as not meeting its admission criteria; and
   - Coordinating the services the client needs.

   This last activity is particularly important. Have you noticed that we keep mentioning coordination?

5. Advocacy

   Advocacy is also a principle of effective case management. Advocacy involves speaking out on issues of concern to apply influence on behalf of a person or persons.

   Advocating for clients can be difficult at times, but it is an important function. Case managers may need to advocate with many systems, including programs, families, and legal systems.

MODULE 3

MODELS OF CASE MANAGEMENT

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Content and Timeline	
Activity	***Time***
Welcome, review of day 1, and introduction to Module 3	20 minutes
Interactive presentation: Models of case management	70 minutes
Break	*15 minutes*
Interactive presentation: Models of case management	60 minutes
Small-group to large-group discussion: Models of case management	60 minutes
Lunch	*60 minutes*

Module 3 Goals and Objectives

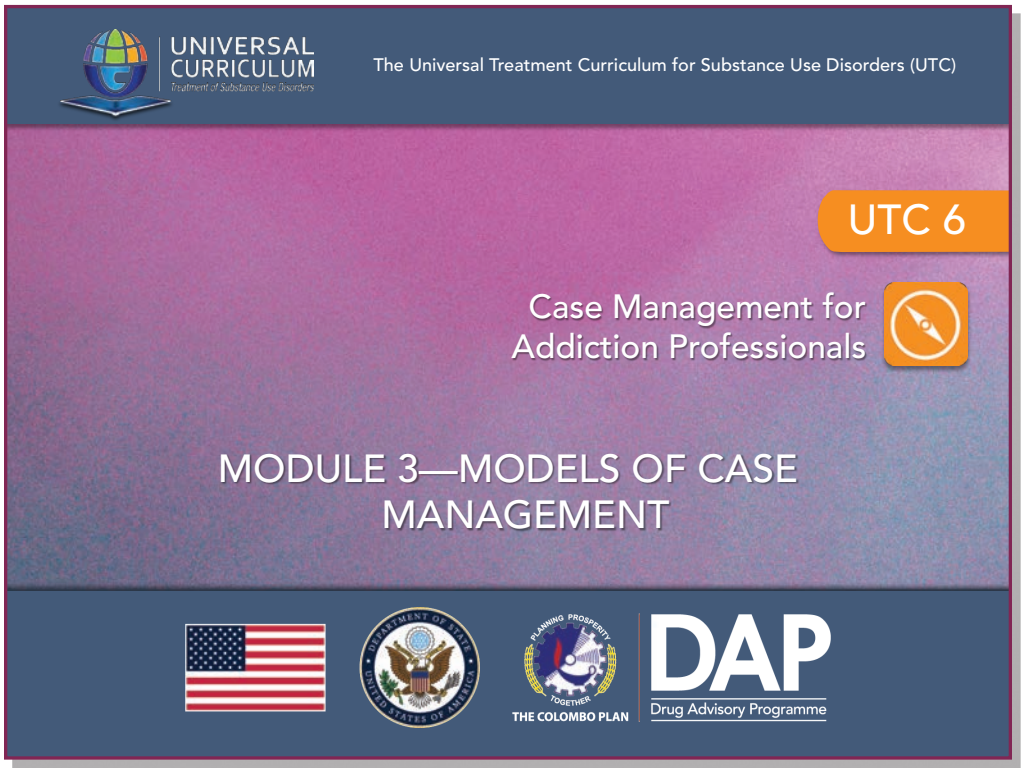
Training goals

- To provide an overview and examples of four models of case management used in substance use disorder treatment; and
- To provide participants with an opportunity to examine their own programs' case management approaches.

Learning objectives

Participants who complete Module 3 will be able to:

- Describe three models of case management;
- Identify which models are currently used in their programs;
- Identify ways in which changes may be appropriate; and
- Analyze their own work within the context of these models.



Review

- Review Post-its
- Discuss individually
- Discuss in group

3.2

Module 3 Learning Objectives

- Describe 4 models of case management
- Identify which models are currently used in your programs
- Identify ways in which changes may be appropriate
- Analyze your work within the context of these models

3.3

Models of Case Management

- Brokerage/generalist
- Strengths-based case management
- Clinical/rehabilitation
- Assertive Community Treatment

3.4

Definitions of Brokerage/Generalist

- Brokerage: Process of negotiating services on behalf of someone else
- Generalist: Someone with knowledge in a wide range of services
- In this brief approach to case management:
  - client's needs are assessed
  - services required are identified and
  - client is helped to access it in just one or two contacts

3.5

Significant features of Brokerage/Generalist model

- Limited duration of contact wherein clients are linked to service providers
- Assumed that clients will use the services if they know where and how to access help
- Little or no monitoring and advocacy
- Works well when services are integrated and putting the client in touch with the system is sufficient

3.6

Advantages of Brokerage/Generalist model

- A quick-response approach that provides immediate results to clients
- As role of the case manager is largely 'assess, plan and link', more clients can be helped
- As monitoring and advocacy is less, costs are lower and the model can be used by programs with limited resources or narrowly defined services
- Works well for clients who are 'not economically deprived, have significant intent and sufficient resources'

3.7

Challenges in Brokerage/Generalist model

- More responsive to immediate needs rather those requiring longer term support
- Inadequate advocacy
- Not appropriate for clients with late-stage SUDs or in very early recovery

3.8

Example of Brokerage/Generalist model

- The community has a well integrated system for clients with HIV
- Case manager conducts assessment and provides referrals during the initial session
- Once a client is referred, the system keeps tracks of the client and provides ongoing services
- The case manager 'hands off' client to the other programs which will provide the identified services

3.9

Question

- Catch paper
- Pick an answerer
- Ask question
- Answer question
- Discuss

3.10

Strengths-based case management model

- Focuses on clients' strengths, self-direction and use of informal networks such as family and friends rather than rely only on agency resources
- Helps clients take the lead in identifying needs, take control over the search for resources to address these needs
- Case manager functions as a consultant to facilitate empowerment
- Developed initially to help persons move from institutional care to independent living

3.11

Significant features of Strengths-based case management model

- In the strengths-based model, the case manager:
  - Actively supports clients in the process of accessing resources
- But goes beyond accessing resources to:
  - Encourage clients to build on personal strengths
  - Empower clients and their families through opportunities for growth, skill development, and education

3.12

Advantages of Strengths-based case management model

- Clients are helped to access resources for recovery based on their unique needs
- Significant component of advocacy helps to counter stigma
- Emphasizes strengths and capabilities rather than the pathology thereby shifting the focus from the disease to the client's potential for growth

3.13

Challenges in Strengths-based case management model

- Clients with late-stage SUDs or in very early recovery often have inadequate strengths to draw from
- Works well for some, such as those whose SUD has not reached a severe stage or for clients well into recovery
- The advocacy and client-driven planning can sometimes cause problems with the other team members

3.14

Example of Strengths-based model - Dasima

- Dasima with SUD related to cocaine use, has limited education, is estranged from her family and has many friends with SUD
- She is motivated to give up cocaine use, intelligent, has excellent verbal skills, presents ideas persuasively and has social contacts with non-substance using people leading, stable lives

3.15

Example – Dasima: Role of case manager

- By drawing on her strengths, the case manger addresses problems identified in intake and by Dasima herself by:
  - Identifying resources available
  - Presenting the options available
  - Directing her to these resources
  - Encouraging her to negotiate the services using her skills identified
  - Advocate for her if needed

3.16

Example – Dasima: What can be done

- Intelligence and verbal skills are her core strengths
- Encourage her to shift social focus from those with SUD to the non-substance using people leading stable lives
- Help her find the appropriate 12-Step group from those operating in her community
- If she wishes to, find ways to address family issues and rebuild relationships with her family members
- Continue to support and be available as a resource for a long period of time

3.17

Ways to be an Ongoing Resource

- Draw on strengths and allow client to operate independently
- Encourage client to build healthy social contacts
- Help identify new opportunities e.g. employment
- Answer questions about a service environment
- Ongoing process of providing guidance, information, and encouragement, to enable clients to fully apply their strengths

3.18

Question

- Catch paper
- Answer question
- Discuss

3.19

Break

15 minutes

3.20

Clinical/Rehabilitation Model

- The clinical care provider also functions as the case manager.
- The same individual plays both roles
- As a clinician, the counselor provides treatment (counseling) and also undertakes resource mobilization for client as a case manager

3.21

Significant features of Clinical/ Rehabilitation model

- In this model, which is the most widely used, the case manager also provides clinical services and is able to:
  - Identify needed resources suitable to the client
  - Recognize the social, emotional, and mental barriers to services
  - Continue to work on case management issues as long as the therapeutic relationship continues

3.22

Advantages of Clinical/ Rehabilitation model

- This model has practical advantages such as when:
  - Separating clinical and case management services for an extended period is not possible
  - Client has co-occurring disorders and the same professional can provide effective treatment
  - Program lacks resources and one professional can perform both services"

3.23

Challenges of Clinical/ Rehabilitation model

- Skill in both areas are needed, requiring extensive training and experience
- Inadequate involvement in advocacy and co-ordination
- Can be overwhelming for a clinician to handle both roles

3.24

Example of Clinical/ Rehabilitation model

- Women with SUDs have special needs
- Building relationships and working towards empowerment are critical issues in treatment
- Having one treatment team member handle issues makes it easier to address their unique need

3.25

Question

- Catch paper
- Pass to another
- Answer question
- Discuss

3.26

Assertive Community Treatment (ACT) Model

- Highly individualized treatment is provided directly to clients in their home and community by a multidisciplinary team
- The ACT team works collaboratively to provide range of services from treatment to other support services
- Provides services 24 hours a day year round
- Specific time limits and goals are established at the beginning of treatment

3.27

Significant features of ACT model

- Goal is to prevent recurrent episodes of illness, meet basic needs, improve functioning and lessen family's burden of providing care
- Provide services to treat:
  - mental illness including medications
  - SUD such as group therapy
- Skill training to cope with problems of daily living such as time management, budgeting
- Support and advocacy for employment, education, housing etc.

3.28

Advantages of ACT model

- Services are provided in the client's home setting providing easy access
- Client friendly - provided whenever needed
- Case managers reach out to clients and act proactively to prevent recurrent problems
- Works well for those with co-occurring mental disorders who have difficulty in accessing traditional out-patient services

3.29

Challenges in ACT model

- Trained team with skills to deal with range of issues is required
- Resource demands may be increased due to:
  - Intensive work calls for lighter case loads
  - Need for involvement of a team
  - Transportation is needed

3.30

Example of ACT

- ACT approach used with diverse populations with SUD - homeless, severe mental illness and parolees with injecting drug use
- ACT team in USA provides services for:
  - SUD treatment and later on relapse prevention
    - finding employment
    - medical, HIV related issues etc.
  - recovery support groups such as 12-step groups
- A single case manager acts as the primary contact for the client and co-ordinates all the services

3.31

Question

- Volunteer
- Read question
- Answer question
- Discuss

3.32

Small-Group Exercise

- Stretch your legs
- Talk to your neighbors
- Count off

3.33

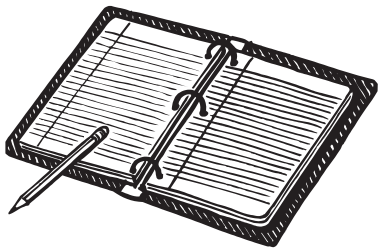
Small-Group Exercise Topics To Discuss

- What models are currently used in your program?
- What works well?
- What does not?
- What now?

3.34

Reflection

- How do these models fit into your programme?
- Did you learn anything that might help improve the case management your program provides?
- How might you want to modify your program's approach?



3.35

Lunch

60 minutes

3.36

Brokerage/Generalist Model

- Brokerage/generalist models try to identify clients' needs and help clients access identified resources.
- Planning may be limited to the client's early contacts with the case manager rather than an intensive long-term relationship. Planning focuses on connecting the client to another program or service.
- Ongoing monitoring, if provided, is fairly brief and does not include active advocacy.
- The brokerage/generalist model is sometimes considered inferior because of the limited nature of the client–case manager relationship and the absence of advocacy.
- Nonetheless, this approach shares the basic foundations of case management and has proved useful in particular situations.
- The relatively limited nature of the relationship in this model allows the case manager to provide services to more clients.
- This approach is appropriate when treatment and social services in a certain area are relatively integrated and the need for monitoring and advocacy is minimal.
- The model works best with clients who are not economically deprived and who have significant motivation and resources.
- Small programs or programs that offer narrowly defined services may be in an ideal position to offer brokerage-only services.
- This model allows for a quick-response approach that provides immediate results to clients by linking them with programs or services that will provide ongoing support.

Strengths-Based Model

- The strengths-based perspective of case management was originally developed to help people with persistent mental illness move from institutionalized care to independent living.
- The model provides clients with support for taking direct control over their search for resources, such as housing and employment.
- It examines clients' strengths and determines the assets they can use to obtain resources.
- To help clients take control and find their strengths, this model encourages use of informal helping networks (as opposed to institutional networks).
- The model emphasizes the client–case manager relationship.

Clinical/Rehabilitation Model

- Clinical/rehabilitation approaches to case management are those in which clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the same person.
- The clinical/rehabilitation approach has been widely used in the treatment of people with diagnoses of both substance abuse and psychiatric problems.
- An advantage is that the client has only one point of contact within a program.
- Caseloads should be light, because providing multiple services is time-consuming.
- This model is often used by default, because many SUD treatment programs do not hire people to provide only case management services. In these cases, caseloads often remain high, which can lead to counselor burnout compassion fatigue.

Assertive Community Treatment (ACT) Model

- ACT involves contact with clients in their homes and natural settings.
- It focuses on the problems of daily living.
- Assertive advocacy is important.
- Caseloads must be light.
- The case manager and client have frequent contact.
- A team approach is followed with shared caseloads.
- Case managers generally make a long-term commitment to their clients, although there are now some time-limited adaptations of ACT.
- ACT may be indicated for clients who face considerable barriers to accessing or engaging in treatment.
- The ACT model has been used in the United States with people on parole with histories of injecting drugs. Case managers provided direct counseling services and worked with clients to help them develop skills to function successfully in the community. Case management staff also provided family consultations and crisis intervention services. In addition, they operated group sessions to provide skills training in areas such as employment and relapse prevention.
- ACT is a highly staff- and time-intensive model.

Module 3—Models of Case Management, Summary

- There are four models of case management that are often used in substance use disorder (or SUD) treatment programs. It's important to understand that, whereas some programs use a specific model, most use a mixture of two or more models to individualize case management for clients. These models are:
  - Brokerage/generalist;
  - Strengths-based case management;
  - Clinical/rehabilitation; and
  - Assertive community therapy (or ACT).

The brokerage/generalist model of case management

- In the brokerage/generalist model:
  - "Brokerage" means the process of negotiating services on behalf of another.
  - A "generalist" is a person with some knowledge in a wide area of services; this person is not necessarily a specialist or an expert in any one field.
- In this brief approach to case management:
  - Client's needs are assessed, services required are identified and client is helped to access it in just one or two contacts.
  - The duration of contact is limited wherein the client's needs are identified and the client is linked to the necessary service providers.
  - Services are available in the community and it is assumed that clients will use the services if they know where it is available and how they can access it.
  - The case manager does not engage in long term monitoring of the client and the role for advocacy is also limited.
- This approach works well when services are integrated and putting the client in touch with the system is sufficient. The client is essentially 'turned over' into the care of the service provider. This is a quick-response approach that provides immediate results to clients by linking them with programs or services that will provide ongoing support. The case manager's role is largely limited to 'assessment, planning and linking', it does not place too much demand on the case manager and more clients can be helped.
- Some of the features of the brokerage/generalist model of case management include:
  - Because case managers are involved only early in the clients' treatment and need for monitoring and advocacy is less, costs are lower and the model can be used by programs with limited resources or narrowly defined services. This is because a program may not have the resources or mission to provide the broader range of services that case management can coordinate.

- The model works well for clients who are 'not economically deprived, have significant intent and sufficient resources'. The model can be more effective for clients who can "work the system," that is, have the skills to coordinate their own care and advocate for themselves as necessary. Generally, these clients tend to have greater social and/or financial resources.

- This approach may be more responsive to immediate needs such as housing than ones in which the case managers first develop close personal relationships with their clients and provide long term monitoring and support. A common criticism of the approach is that the relationship between the case manager and client is limited and the case manager doesn't perform an advocacy role. The case manager may not know about problems in the client's later services and thus may not be able to work on the client's behalf within the system.

- This model is not appropriate for clients in later stages of an SUD or those very early in recovery. These clients will generally not have the resources to negotiate or monitor their own care and may not receive the extensive services they need. Providing monitoring and support on a long-term basis may be more helpful to these clients.

- An example of the brokerage/generalist model of case management. Case managers in a program in a large metropolitan area conduct extensive assessments with clients diagnosed with HIV. The managers typically provide a client with at least two referrals for a variety of services during the initial session.

- Once a client is referred, the system keeps tracks of the client and provides ongoing services.The case manager 'hands off' client to the other programs which will provide the identified services. This quick-response approach provides immediate results to clients, linking them with programs that provide ongoing services. At the end of the assessment, the case manager "hands off" the client to the programs now providing the identified services.

The strengths-based case management model

- Strengths-based case management is very different from the brokerage/generalist model. The strengths-based model deemphasizes the role of the case manager and other service providers in the clients' lives:

    - Focuses on clients' strengths, self-direction and use of informal networks such as family and friends rather than rely only on agency resources. The process starts with the case managers assessing the clients' strengths and recovery capital. They then help clients build on their strengths and identify and develop the resources they need to manage their own lives and recovery effectively.

    - Helps clients take the lead in identifying needs, take control over the search for resources to address these needs. Unlike in the brokerage/generalists and the two other models we'll discuss, clients in this model learn to become their own case managers. For example, they take on the search for their own resources, such as housing and employment.

    - In this model, the case manager is more a consultant to the client than a broker but

provides active advocacy on the client's behalf when necessary.

- This case management was initially developed by the mental health system for patients moving from institutionalized treatment and enable them to live independently in the community.

- Some of the features of the strengths-based case management approach:
  - The approach also provides an active support to clients and the goal goes beyond just accessing services.
  - The case manager is firm but supportive. This support encourages clients and helps give them the confidence they need to apply their personal strengths.
- Strengths-based case management can be effective in the SUD treatment environment for three reasons:
  - First, this model is useful in helping clients access the resources they need to support recovery. For example, the client may be encouraged to become involved in a 12-Step program or more involved in the client's community of faith. These informal networks are those that will continue to be available to clients when formal treatment ends.
  - Second, some people in the general public—and even some professionals—still believe that people with SUDs are in denial or morally deficient. Some may even believe that these clients are therefore unworthy of services. The advocacy component of the strengths-based case management approach can provide an opportunity to counter this belief.
  - Finally, the model focuses on helping clients identify their strengths and capabilities and de-emphasizes a focus on pathology. This model can reinforce the idea that a person with an SUD has many characteristics and is not just a person with a disease. The case manager works with the client with the focus on the client's potential for growth and empowerment rather than the disease.
- For these reasons, the approach has been found to blend readily into current SUD treatment approaches and lead to improved outcomes. These outcomes include employability, retention in treatment, and reduced drug use.
- This model has some drawbacks. This approach, of course, builds on clients' strengths. People in later stages of an SUD or very early in recovery may not have many strengths to draw from. Sadly, some clients have had very difficult lives, even aside from their SUDs. They may not have had the opportunity to develop their strengths. Sometimes, there is simply not enough to build on for this model to work for them.
  - The model is therefore most appropriate for those whose SUD has not reached a severe stage or for clients well into recovery.
  - The advocacy and client-driven planning can sometimes lead to problems for the case manager if the other treatment team members work with different priorities in

mind.

- An example of strengths-based case management: Let's say that you're a case manager and a client—Dasima—comes to you for SUD treatment. The intake assessment identifies the following problems:
  - An SUD, specifically, cocaine use;
  - Limited education;
  - Estrangement from her family; and
  - Association with other people who have SUDs.
- Although 'Dasima' has some serious problems, you find that she has the following strengths:
  - Motivation to deal with her SUD;
  - Obvious intelligence, in spite of her limited education;
  - Verbal skills and an ability to convey ideas clearly and persuasively; and
  - Some social contact with people who do not have SUDs and are living relatively stable lives.
- Your job as a strengths-based case manager is to draw from these strengths to address the problems identified in the intake—plus any needs Dasima may have identified for herself. The case manager will:
  - Identify some of the resources available to her as the first step.
  - Present the options available.
  - Directing her to these resources
  - Encouraging her to negotiate the services using her skills identified
  - Advocate for her if needed.
- A major difference between this and other models is that you don't refer Dasima to other programs; you provide her with appropriate options, direct her to these resources, and encourage her to negotiate her own services, drawing on the skills she's identified.
- This doesn't mean you have no contact with the other programs. Even though Dasima is capable of negotiating systems, she may still need you to advocate for her. After all, some programs may not be used to clients negotiating services on their own behalf.
- Possibly the most important strengths are her intelligence and verbal capability. Their presence means she can negotiate systems for herself and develop her own supports. So your first step is to identify some of the resources available to her.
- Other ways you can help Dasima draw from her strengths include:

- Intelligence and ability to express her needs are some of her strengths and the case manger will draw on it to help Dasima access services.
- Encouraging her to shift her social focus to those people in her life who are not using drugs and living stable lives;
- Helping her find an appropriate 12-Step group in her area;
- Helping her strategize ways to start repairing relationships with her family, if she wishes to do so; and
- Encouraging her to use you as a resource, because you have a long-term relationship with her (unlike in the brokerage/generalist model).

- You have treated Dasima as a capable woman who has strengths she can mobilize to deal with her problems. By recognizing her capabilities, you have helped her develop the confidence and resources to manage her own life and start dealing with her SUD and other problems.
- On the one hand, the main principle of this model is to draw on clients' strengths and allow them to work independently on their own behalf. On the other hand, I just mentioned the case manager's role as an ongoing resource. What does that role entail?
  - First, the case manager may encourage the client to seek more social contacts who are not using substances and then rely on the client's social strengths to do so.
  - Second, the case manager can help identify new opportunities. For example, if the case manager hears about a new employment program, he or she can tell the client about it so that the client can then independently consider the program.
  - Third, even the most skilled client will have questions about the service environment, such as how to apply to a given program.
  - Fourth, there is the ongoing process of building on clients' strengths, primarily by encouraging them and reinforcing their awareness of those strengths and how to mobilize them.
  - Finally, the case manager can keep assessing and supporting progress. Clients with significant strengths are going to grow and develop these strengths even further. This gives the case manager a great opportunity to support clients and build their confidence in their ability to grow and develop their strengths even further.
- In short, the case manager's role in this model is, by providing guidance, information, and encouragement, to enable clients to fully apply their strengths.

The clinical/rehabilitation model

- The clinical/rehabilitation approach involves the case manager's providing two types of service:
  - The clinical care provider also functions as the case manager.

- The same individual plays both roles. In this model, the same treatment professional provides both treatment and case management activities.
- As a clinician, the counselor provides treatment (counseling) and also undertakes resource mobilization for client as a case manager. Resource acquisition, of course, is the function we've been talking about all along: obtaining and coordinating services from other programs for clients.

- In this model, which is the most widely used, the case manager also provides clinical services and is able to:
  - Identify needed resources suitable to the client
  - Recognize the social, emotional, and mental barriers to services
  - Continue to work on case management issues as long as the therapeutic relationship continues
- Since the case manager also provides clinical services in this model, the case manager has unique insight into the services needed, the barriers that may be faced, and the best match between clients and services.
- Keeping ground realities in mind, it is often not possible to separate clinical and case management services for an extended period of time and is more convenient for one person to offer both services.
- Clients have the ease of having to relate to one person who provides both the services. The clinical/rehabilitation approach is particularly effective in treatment of people with co-occurring disorders, such as an SUD and depression.
- It may be more economical for one person to perform two roles than for a program to hire two separate service providers. Often adequate resources are not available in the community and doing both becomes necessary. We have to acknowledge that for many providers, just being a case manager and not providing other services to the client is a luxury they don't have.
- As case managers also function as treatment providers these professionals must be skilled in both areas. This demands a lot from these case managers, including their having extensive training and higher level experience.
- Involvement in clinical issues can compromise the case management activities. This model is often seen as an incomplete model for the lack of emphasis on coordination and advocacy roles. This model places a lot of pressure on the clinician due to various responsibilities involved.
- An example of a program using this model is a facility for women with SUDs.
  - Women with SUDs have special needs.
  - Being able to build trusting relationships and working towards empowerment are critical issues in treatment.

- Having one treatment team member handle issues makes it easier to address their unique needs. which are often appropriately met through a therapeutic relationship with one treatment team member who helps secure resources and also guides implementation of treatment activities.

The assertive community treatment model

- The ACT model provides highly individualized treatment services directly to clients in the comfort of their home and community by deploying a multidisciplinary team to work in the community.
- The ACT team works collaboratively to provide services ranging from treatment on to other support services to help client live independently in the community.
- The multi-disciplinary team ensures that services are available 24 hours a day, all round the year.
- A very important feature is that this model includes specific time limits and goals that are established at the beginning of treatment. Having such goals can motivate clients to put more effort into the treatment and help them, as well as the case managers, focus on their goals.
- Some features and considerations in implementing this model:
  - The ACT model's goal is to prevent recurrent episodes of illness, meet basic needs and enhance quality of life, improve functioning to enhance ability to live independently and lessen family's burden of providing care .
  - Services are provided to treat:
    - Mental illness such as psychopharmacologic treatment anti-psychotics or anti-depressants, supportive therapy such as counseling including family counseling, hospitalization, etc.
    - SUD treatment such as counseling, group therapy, etc
  - Case managers may work directly with clients to help improve life skills and coping abilities by providing behaviorally-oriented skill training. For example, the case manager might teach a client how to budget or help him or her develop a hobby that could support recovery.
  - Case managers also may run group sessions to directly provide skills training in areas such as employment and relapse prevention. Advocacy efforts to ensure access for housing, legal services, transportation, etc. are essential components of this approach.
- There are advantages to using the ACT Model:
  - As services are provided in the client's home setting, barriers to treatment access and engagement are immediately addressed.
  - ACT is a client friendly service as service delivery happens whenever and wherever it is needed. The client does not have to adapt to the set procedures of a treatment programme.

- Case managers reach out to clients and act proactively to prevent recurrent problems. Recognizing the chronic nature of the disorders, case managers maintain 'enforced contact' with clients and intervene quickly to alter the course of the disease and reduce the negative impact.
- ACT works well for the client with co-occurring disorders who may have difficulty getting appointments or problems in understanding or following through with services through the traditional service networks. With ACT, research showed that periods of unemployment reduced, they earned more and expressed greater satisfaction with life when compared to other interventions.

- There are some challenges in implementing the ACT model of intensive case management.
  - ACT team members need to be skilled and trained extensively in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation etc.
  - Resources requirement is high.
    - The case managers must have light caseloads, which can place an unrealistic demand on program resources.
    - Services are delivered directly by a team rather than one case manager who co-ordinates services of multiple service providers, increasing cost.
    - Depending on the client's location, time may be spent getting from the program to the client's home and from one client to another which can place additional demand on the program's resources.
- The ACT approach has been used with diverse populations with SUD - homeless, severe mental illness and parolees with injecting drug use.
- The ACT team works collaboratively to deliver most of the treatment, rehabilitation, and support services required by each client to live in the community. Typical services supported through ACT include:
  - Arranging treatment for SUDs and later for relapse prevention; Finding and helping the client maintain employment;
  - Other conditions; such as medical problems or HIV related issues and
  - Obtaining social support networks, such as established members of the recovery community and 12-Step groups.
- A single case manager serves as the primary contact for the client and coordinates all services.
- More information about the models is in Resource Page 3.1: Models of Case Management.

MODULE 4

STEPS OF CASE MANAGEMENT

Content and timeline 133
Training goal and learning objective 133
PowerPoint slides 134
Resource pages 138
Summary 149

Content and Timeline	
Activity	***Time***
Introduction to Module 4	5 minutes
Small-group presentations: Steps of case management	90 minutes
Break	*15 minutes*

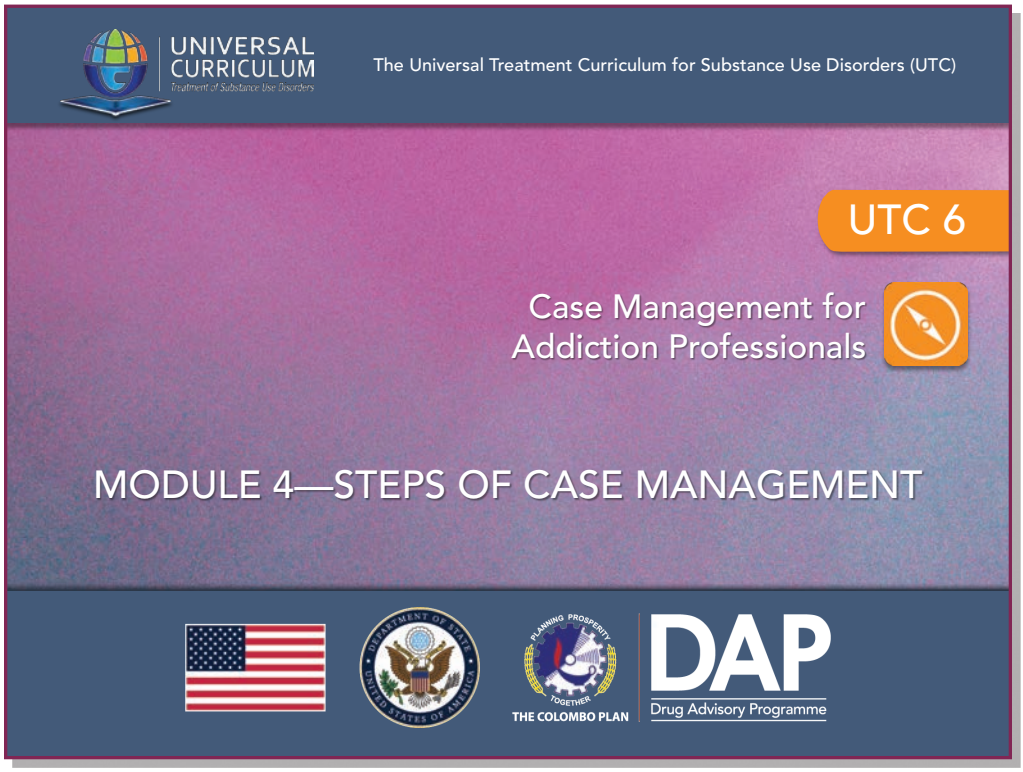
Module 4 Goal and Objective

Training goal

To provide participants with an opportunity to study six steps of case management.

Learning objective

Participants who complete Module 4 will be able to describe six steps of case management.



Module 4 Learning Objective

- Describe 6 steps of case management

4.2

Six Steps of Case Management

- Assessing
- Setting and prioritizing goals
- Developing a referral database
- Preparing the client for referral
- Following up on referrals
- Maintaining referral sources

4.3

Small-Group Presentations

- Break into groups
- Select representatives
- Pick your assigned task

4.4

Small-Group Presentations

- Use resource pages:
  - Resource Page 4.1: Step 1—Assessing
  - Resource Page 4.2: Step 2—Setting and Prioritizing Goals
  - Resource Page 4.3: Step 3—Developing a Referral Database
  - Resource Page 4.4: Step 4—Preparing the Client for Referral
  - Resource Page 4.5: Step 5—Following Up on Referrals
  - Resource Page 4.6: Step 6—Maintaining Referral Sources
- Prepare a presentation that includes a role-play
- Use newsprint, markers, anything else
- Be creative!

4.5

Break

15 minutes

4.6

Resource Page 4.1: Step 1—Assessing

The first step in effective case management is assessing a client's real-world needs.

Assessment is the basis for all case management activities. Although someone else (such as a treatment counselor) might actually conduct the assessment, case managers need to understand the process and use all available assessment information in planning case management activities.

Much has been written about assessment and assessment tools. UTC 5 provided detailed information on the assessment process; this Resource Page provides a basic review.

Areas of Assessment

A thorough assessment includes collecting the following information about the client:

1. **Background and current status**
    - Family situation and relationships;
    - Trauma history;
    - History of domestic violence (either as a batterer or as a survivor);
    - Marital status;
    - Cultural, racial/ethnic identity;
    - Sexual identity;
    - Religious Affiliation;
    - Past and present legal involvement;
    - Financial and work situations;
    - Education;
    - Housing status;
    - Employment status;
    - Strengths and resources;
    - Goals for treatment.
2. **Past and current substance use**
    - Age at first use;
    - Substances used (including alcohol);

- Amounts used;
- How used (e.g., injection, orally);
- Patterns of use;
- Consequences of use;
- Treatment episodes; and
- Family history of substance use problems.

3. **Medical conditions or complications, such as:**
   - Injection-related medical issues;
   - HIV/AIDS;
   - Tuberculosis;
   - Hepatitis;
   - Sexually transmitted diseases;
   - Liver disease;
   - Physical disability; and
   - High blood pressure, diabetes, and other health problems.
4. **Emotional/behavioral/cognitive status**
   - Family history of mental health problems;
   - Client history of mental health problems, including diagnosis, hospitalization, and other treatment;
   - Current symptoms and mental status;
   - Medications and history of medication adherence (Medication may affect behavior. Adherence or nonadherence to medication regimens can provide some idea of how well a client will follow through in other areas.); and
   - Cognitive function (e.g., Does the client have a cognitive deficit? Will he be able to remember appointments? Can she understand and follow through on directions?).
5. **Readiness to change (this needs to be reassessed often)**
   - Where is the client in the stages of change cycle?
   - What is the client ready to work on? (Some clients will be agreeable to one case management option, but not another.)
   - How ready is he or she to take a step toward change?

6. **Relapse or continued use potential (related to readiness to change)**
    - How is the client managing cravings?
    - Can he or she identify personal relapse triggers?
    - What is the client's recovery environment?
    - What supports does he or she have for recovery?
    - Is he or she still spending time with friends or family members who use drugs or alcohol?
    - Does his or her family support recovery?
7. **Immediate threats to the client's safety—Is the client:**
    - Expressing thoughts of suicide?
    - Threatening harm to someone else?
    - In danger?

Suspicions of immediate danger should be investigated by asking questions: Do you feel safe at home? Do you feel safe in your current relationship? Is someone threatening you now or making you feel unsafe?

8. **General ability to function**
    - Ability to obtain and follow through on medical services;
    - Ability to apply for benefits on his or her own;
    - Ability to obtain and maintain safe housing;
    - Skill in using social service programs; and
    - Skill in accessing mental health and substance abuse treatment services.

Assessing these areas of functioning helps the case manager determine the client's strengths, degree of impairment, and barriers to the client's recovery. These areas can be assessed by asking the client about his or her past experiences (e.g., When did you last see a doctor? Did you make the appointment yourself? Are you receiving government benefits? Did you complete the application yourself?).

The case manager may have to perform many services on behalf of the client until the client can master these skills.

9. **Vocational skills**
    - Basic reading and writing skills;
    - Ability to follow instructions;
    - Ability to arrange for necessary transportation;

- Manner of dealing with authority;
- Ability to be punctual; and
- Communication skills.

Of course, assessment also includes evaluating client strengths and recovery capital.

Conducting an Assessment

Using reflective listening and open-ended questions can elicit much more information than close-ended questions. Ask clients:

- What drugs have you used in the last year? Versus: Do you use drugs?
- Tell me about your heroin use. Versus: Do you inject heroin?
- What is your heroin use like in a typical day? Versus: Do you use heroin more than once a day?

One effective, nonthreatening technique to use when conducting an assessment is the "sandwich" approach. In this approach:

- The bottom "slice of bread" is a conversation; you build rapport with the client by welcoming him or her, chatting a bit, listening to concerns, and asking whether he or she has questions.
- The sandwich "filling" is a more structured interview. You ask specific (preferably open-ended) questions in the areas noted above.
- The top "slice of bread" is, again, a conversation. You confirm the client's readiness for interventions, create with the client an appropriate plan of action, confirm that the plan is what the client is ready and willing to do, provide affirmation, and thank the client for coming.

Resource Page 4.2: Step 2—Setting and Prioritizing Goals and Objectives

Goals are general statements from the client about what he or she is hoping to get out of the treatment experience (e.g., "I want to get a job"; "I want a closer relationship with my family").

Each goal, especially a long-term goal (e.g., completing schooling), should be broken down into short-term objectives.

Objectives are the actions to be taken to achieve a goal or to address barriers to goal achievement.

Effective objectives are:

- Specific (What exactly will you accomplish?);
- Measurable (How will you know when you have accomplished an objective?);
- Attainable (Is achieving this objective realistic with effort and commitment? Do you have the resources to achieve this objective? If not, how will you get them?);
- Relevant (Why is this objective significant to your life? Do you value it?); and
- Time limited (When will this objective be achieved?).

Distinct, manageable objectives keep people from feeling overwhelmed and provide a benchmark against which to measure progress.

You can help a person break down goals into manageable, measurable objectives by asking questions such as:

- What will be your first (or next) task?
- What will you do in the next 1 or 2 days (weeks)?
- What have you already been doing to achieve this goal? What else can you do?
- Who can help you?
- On a scale of 0–11, how confident are you that you will do this next task?

Objectives need to be prioritized. A client in recovery can easily be overwhelmed by working on too many objectives at the same time. Generally, objectives can be prioritized in the following order:

- Emergencies;
- Basic needs; and
- Other needs.

Emergency needs include:

- Life-threatening situations (e.g., serious illness, suicidal thoughts);
- Life-threatening withdrawal symptoms such as those from CNS depressants;
- Family violence; and
- Disaster situations.

Basic needs include:

- Employment and money;
- Food;
- Housing and utilities (e.g., electricity and water);
- Safety; and
- Transportation.

Other needs are those that are not considered emergency or basic needs:

- General medical care;
- Child care;
- Schooling; and
- Client goals for the future.

Meeting clients' emergency and basic needs comes first. After that, the case manager can help clients prioritize objectives or next tasks by asking questions such as:

- What would you like to work on first?
- Which of the objectives that we've talked about are most important to you?
- Which of these objectives do you think you can achieve first?
- Which of these objectives do you think will help you most in your recovery?

Other important elements of setting objectives include:

- Identifying needed resources (including referrals) and support; and
- Identifying possible barriers to and solutions for achieving objectives.

Successful completion of an objective provides the client with the satisfaction of gaining a needed resource and demonstrating success. Failure to complete an objective can be emphasized as an opportunity to reevaluate one's efforts and any barriers to achieving the objective. In this situation, the case manager can help the client come up with alternative approaches or begin an advocacy process.

A deliberate, careful approach to identifying client goals and objectives offers benefits that go beyond actual achievement of goals. Clients benefit by:

- Learning a process for systematically setting goals;
- Understanding how to achieve desired goals and objectives through the accomplishment of smaller objectives;
- Gaining mastery of themselves and their environment through brainstorming ways to overcome possible barriers to a goal or objective; and
- Experiencing the process of accessing and accepting assistance from others in setting goals and attaining them.

These and other outcomes make planning and setting goals and objectives as important as the final outcome in some cases: It's the journey, not just the destination.

Resource Page 4.3: Step 3—Developing a Referral Database

Case managers need to maintain a current list, or database, of referral resources. These resources may be local, district, tribal, or provincial social service organizations, including governmental agencies, nongovernmental organizations, and faith-based organizations.

These organizations should include but are not limited to:

- Treatment programs for substance use disorders (SUDs) (residential, hospital based, outpatient);
- Treatment programs for mental disorders (crisis care, hospital based, outpatient);
- Resources for general medical care;
- HIV/AIDS services (voluntary counseling and testing and medical services, including antiretroviral treatments);
- Legal services;
- Family therapy services;
- Educational and training resources;
- Family planning and other services for pregnant and postpartum women;
- Housing programs (housing financial assistance, halfway houses, transitional living programs);
- Vocational services programs (job referral, sheltered workshops for those with mental or physical disabilities, job skills training);
- Programs offering general financial assistance; and
- Community peer support groups for those with SUDs (Narcotics Anonymous and so on), those living with AIDS, and other special populations, such as women, female and male sex workers, and men who have sex with men.

When creating a resource database, the case manager should include everything he or she knows about each organization or group, including its locations, target audience, criteria for admission, how it accepts referrals, and potential barriers. It also can help to have names of specific people to contact and to develop relationships with these people.

The case manager also can establish and maintain relationships with community groups, programs, other professionals, government entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and address unmet needs.

Resource Page 4.4: Step 4—Preparing the Client for Referral

Clients need to be prepared for referrals. The case manager can help a client understand the need for a particular referral and how it can help the client.

The case manager also can use active listening skills to identify and acknowledge how the client is feeling about getting help. Asking for help is often one of the most difficult things a person has to do, and people often have feelings that may prevent them from asking for help. Some common feelings include:

- Shame;
- Fear;
- A sense of powerlessness; and
- Distrust.

Cultural beliefs also can influence how a client views asking for help.

The case manager also can initiate a discussion about possible barriers as a follow through on the referral (Can you see any reason why this might not work for you?). There may be a number of possible barriers, such as the emotional factors noted above, and more concrete reasons, such as lack of money or child care. The case manager can use problem-solving techniques to help the client find ways to address barriers.

Clients also need to know generally what to expect. The case manager obviously should give the client basic and necessary information: the name of the program, the phone number, the address, and the name of a contact person (if possible). The case manager also should provide as much specific information as possible, such as:

- A description of the services the program provides;
- The hours the program is open;
- Any fees charged; and
- The admission process.

If the case manager has a professional relationship with someone at the program, it can help the client to know that and to hear a little about the person (Miss Tran is soft spoken and caring; I think you'll like her).

Once the client accepts the referral, the case manager needs to decide whether the client or the case manager should make the first contact. If it is an emergency referral (e.g., if the client is seriously ill or has suicidal thoughts), it is generally in the client's best interest for the case manager to make the referral and, often, accompany the client.

In nonemergency situations, and when the referral source does not require a formal referral, the case manager may choose to let the client make the first contact. This decision should be based on the case manager's assessment of the client's functioning. Some clients may need considerable help accessing services.

Resource Page 4.5: Step 5—Following Up on Referrals

Once a referral has been made, the next step is followup. The next time the case manager sees the client, he or she should:

- Ask the client whether he or she used the referral;
- Give positive feedback if the client contacted the referral source (That took a lot of courage; I am glad you were able to follow through);
- Ask how things went (the client may have kept his or her appointment but didn't feel comfortable, was not greeted warmly, or for some reason didn't like the organization; this should lead to a discussion of alternatives);
- Ask why a client did not use a service (Tell me more about why you did not keep your appointment); and, when necessary,
- Initiate another discussion of barriers or reexamine how important the goal and referral are to the client.

Part of follow-up is continuing to support and participate with the client by:

- Exchanging relevant information with the program or professional to whom the referral is being made, in a manner consistent with confidentiality standards;
- Summarizing relevant aspects of the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment;
- Contributing as part of the client's treatment team;
- Coordinating all treatment and social services activities provided to the client by other resources; and
- Periodically reviewing the client's goals and making other referrals as needed.

Resource Page 4.6: Step 6—Maintaining Referral Sources

The case manager must maintain his or her referral database over time. What is the likely outcome of referring a client to a program that no longer exists? To a contact person who no longer works there?

The case manager also needs to know what to send with a client:

- Does the program need a formal referral form?
- Does the client need to complete some paperwork before the appointment?
- Are certain types of identification required?

These things can change over time.

In general, maintaining a referral database involves:

- Making sure the following information in the database remains current:
  - Program name;
  - Address;
  - Telephone number;
  - Contact people;
  - Type(s) of services provided;
  - Eligibility requirements;
  - Service area;
  - Program caseload or capacity; and
  - Referral procedures;
- Continuously assessing and evaluating referral resources to determine their effectiveness;
- Providing appropriate feedback to programs about clients' reports of their experiences;
- Making sure clients can actually access the services;
- Keeping track of which clients seem to do best with which programs; and
- Adding new service programs or pilot programs to the list.

Case managers also should develop professional relationships with appropriate people at other programs. These relationships can smooth the way for referrals and provide conduits for updated information about other programs' services and policies.

Module 4—Steps of Case Management, Summary

- With few exceptions, no matter what model of case management a counselor uses, he or she will generally need to follow each of these six steps:
  - Assessing;
  - Setting and prioritizing goals and objectives;
  - Developing a referral database;
  - Preparing the client for referral;
  - Following up on referrals; and
  - Maintaining referral sources.

Descriptions of each step are in Resource Pages 4.1–4.6.

MODULE 5

INTEGRATING LEARNING INTO PRACTICE

Content and timeline..... 153
Training goals and learning objective 153
Resource page..... 154

Content and Timeline	
Activity	***Time***
Small-group exercise: Developing a practice integration plan	60 minutes
Day 2 and overall training evaluations	10 minutes
Program completion ceremony and socializing	30+ minutes

Module 5 Goals and Objective

Training goals

- To encourage participants to think about resources, barriers, and strategies for change; and
- To provide an opportunity to develop a personal practice integration plan.

Learning objective

Participants who complete Module 5 will have developed a personal practice integration plan.

Resource Page 5.1: Practice Integration Plan

1. The most important thing I learned from this training, and don't want to forget, is:

_____

_____

_____

2. How we could integrate a case management into the current system or practice?

_____

_____

_____

3. Some things that could interfere with my plans are (e.g., anticipated barriers):

_____

_____

_____

4. Ways I could overcome these barriers include:

_____

_____

_____

5. The following people (include supervisors, potential mentors, and so on) and resources (further training, reading) could help me in the following ways:

Person or Resource	***Possible Ways To Help***

APPENDIX A—GLOSSARY

co-occurring disorder (COD)	Both a substance use disorder and a mental or medical disorder (or both).
coordinated services	Uninterrupted activities that are integrated among service providers.
fragmented services	Separate activities that do not support access for the client.
inter-program case management	Coordination of services provided among separate programs, such as a substance use disorder treatment program and a medical clinic.
intra-program case management	Coordination of services provided within one program, such as different levels of care offered within the same program.
recovery capital[1]	Internal and external resources that can be drawn on to initiate and sustain recovery. Addiction professionals can influence three types of recovery capital: personal, family/social, and community.

[1]Cloud, W., & Granfield, R. (2004). A life course perspective on exiting addiction: The relevance of RC in treatment. *Nordic Council for Alcohol and Drug Research, 44,* 185–202.

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Washington State Program of Assertive Community Treatment (PACT) Program Standards

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- Beatrice Kathungu, Ph.D, Lecturer, Kenyatta University, Kenya
- Prof. Dr. Mahmood Nazar Mohamed, Deputy Vice-Chancellor, Asia Metropolitan University
- Shirley Mikell, Project Manager, SME Consulting, LLP, USA
- Stephanie Lusk,Ph.D, Assistant Professor, University of Arkansas, USA
- Martha Hurley, Ph.D., Department Head and Professor, Texas A&M University Commerce, USA
- Hendrée Jones, Ph.D, Executive Director, UNC Horizons, USA
- Dato' Zainuddin A. Bahari,Resource Person/Consulting Trainer, Malaysia
- Ma. Elena (Malyn) Cristobal,Family Therapist, Private Practice, Philippines
- Ma. Veronica Felipe, Director,Colombo Plan Drug Advisory Programme, Sri Lanka
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